NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Tenth

COMMON REVIEW MISSION

Report 2016

Tenth CRM

Common Review Mission

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Report 2016

This report has been synthesised and published on behalf of the National Health Mission by its technical support institution; National Health Systems Resource Centre (NHSRC) located at NIHFW campus, Baba Gangnath Marg, New Delhi-110 067.

We gratefully acknowledge the contributions made by consultants and officers in the NHM Division of the MoHFW. We also place on record our deep appreciation and gratitude to participants from other Ministries, Public Health Institutions, Civil Society and Development Partners who have all contributed to this Common Review Mission Report.

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MESSAGE

Common Review Missions (CRMs) have played a key role as a key monitoring tool particularly for assessing the progress of National Health Mission (NHM) implementation on ground. It has proven to be a valuable mechanism for the Ministry of Health & Family Welfare to review programme and policy changes and I am sure CRM reports have proved useful to States as an independent feedback about their strengths and weaknesses in programme implementation. The progress of its trajectory is also visible from how CRMs have transitioned from measuring inputs to outputs and outcomes such as service delivery and quality parameters.

It is heartening to note that this 10th Common Review Mission report strongly bears out the fact that NHM continues to play an important role to improve the health status of our people by strengthening the public health system and improving its coverage and quality of services. While this decadal journey has brought about many positive changes, some persistent challenges still exist such as those relating to addressing health inequities, universal health coverage and out of pocket expenditure. The 10th Common Review Mission report has delineated clearly both the improvements as well as the challenges faced by the public healthcare system in resolving the above mentioned issues. One of the most encouraging developments is the enthusiastic adoption and implementation of the NHM Free Drugs and Diagnostic Service initiatives by the States, which will go a long way in improving quality and comprehensiveness of care and reduce out of pocket expenditure.

The increased availability of better infrastructure and human resources for health even in difficult to access areas at levels closer to the community is being supplemented by the increase in the number of First Referral Units and mobile medical units.

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The success of programmes designed to improve the quality of care at both facilities and at the community level proves that good quality healthcare can be extended by the public health system to those who need it most. It is important to build on these successes and expand it to all areas of healthcare within the facilities and in outreach services and make these practices an integral part of the ever evolving healthcare system.

This annual review exercise of NHM has evolved into an exhaustive assessment of health sector performance as well as a guide map to further improve the system by mid-course correction. I thank all the team members, particularly the experts who were part of this exercise for their invaluable inputs and would like to use this occasion to reassert our commitment to the goals of NHM.

(Jagat Prakash Nadda)

सी.के.मिश्रा
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Secretary

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Ministry of Health & Family Welfare

MESSAGE

The Common Review Mission (CRM) is a monitoring and evaluation mechanism in-built into the NHM. The CRM reports have consistently provided valuable insights into the progress achieved by NHM against set objectives as well as critical analysis of its performance with health system perspective in programme design and barriers in programme implementation. More pertinently, they are also an important channel for feedback from community on the delivery of healthcare services by public health facilities. From a governance point of view, it provides both the centre and the States an opportunity to take stock of the present situation and adopt appropriate mid course policy/strategy changes.

The progress made in infrastructure, service delivery, service utilisation and quality of services are positive developments. However, undoubtedly there is scope for improvement in some critical areas. These include adherence to standard protocols of care, addressing high OOPE, reducing health inequities and pro-active inter-sectoral coverage to address the social determinants of health. The recommendations from this report point at strengthening and optimal utilisation of the human resources for health as well operationalizing effectively the community based components of the Mission including enhanced role of PRIs. Issues of communication gaps, information sharing systems and urban health must also be resolved. I am sure that these recommendations will be taken into consideration by the states when preparing their State implementation Plans.

I would like to convey my appreciation to all the team members who undertook this mammoth exercise and helped prepare this report. I am sure it has been an enriching experience to all involved and I am sure the observations and recommendations will help move the mission forward.

(C.K. Mishra)

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29th May, 2017

MESSAGE

It has been more than 10 years since the commencement of the National Health Mission. The Mission originally began as the National Rural Health Mission with the aim of strengthening the existing health system and improving its coverage and quality. The focus has been to address systemic bottlenecks related to provision of primary and secondary care in rural areas. In the next phase, the National Health Mission also included the urban areas under the aegis of the National Urban Health Mission in 2013. There has been a renewed commitment to make all public health facilities user friendly. The vast advances that the public health system has seen both in terms of service provision as well as utilisation are a sign that the National Health Mission is serving its purpose.

The vast improvements with regard to maternal and child health is a milestone achievement of the NHM. The push to reduce out of pocket expenditure and the focus of reaching the unreached have been other hallmarks of the Mission. The NHM has also resulted in some major governance reforms at both the National and State level.

The current report, based on the findings of the 10th CRM, has provided welcome accounts as to the increase in the number of people utilising the public health care facilities, both in-patient and out-patients. With the launch of the new schemes related to making drugs and diagnostics free for all those in need as well as the push to improve last mile services has shown better than expected results. The expansion in the range of services provided at the primary health centre level along with the sustained focus on improving the quality of the services provided has improved the community acceptance and subsequent uptake of public health care services.

On the flip side, while overall there has been marked improvement, there continues to be substantial variation in the pace of this progress. The present challenge is then to address this variation and provide the required resources to help resolve this situation. The inter-sectoral convergence, involvement of PRIs and improving the referral chain mechanisms and institutional capacity remain important areas of concern.

The CRM is an important monitoring and review mechanism of the NHM. Its observations and recommendations are considered earnestly to further improve the impact of the Mission. I assure all stakeholders that there will be constant followup on action taken on the observations of the report. I thank all the participants for their efforts and valuable time. I request them to remain actively engaged, and facilitate followup and implementation of the recommendations.

(Dr. Arun K Panda)


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CONTENTS

ABBREVIATIONS

AGCA	Advisory Group on Community Action
AMTSL	Active Management of Third Stage of Labour
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
APHC	Additional Primary Health Centre
API	Annual Parasite Index
ARC	ASHA Resource Centre
ART	Anti retroviral Treatment
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric & Neonatal Care
BMO	Block Medical Officer
BMWM	Bio-Medical Waste Management
BPHC	Block PHC
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
BPL	Below Poverty Line
CAH	Community Action for Health
CBOs	Community Based Organizations
CEmONC	Comprehensive Emergency Obstetric & Neonatal Care
CHC	Community Health Centre
CMO	Chief Medical Officer
CMOH	Chief Medical Officer Health
CRM	Common Review Mission
CT Scan	Computed Tomography Scan
DH	District Hospital
DHAP	District Health Action Plan
DLHS	District Level Household Survey
DOTS	Direct Observation Therapy - Short-course
DPM	District Programme Manager
DPMU	District Programme Manager Unit
DTC	District Training Centre
DWCD	Department Women & Child Development
EDL	Essential Drug List
EmONC	Emergency Obstetric & Neonatal Care
EMRI	Emergency Management and Research Institute
FMG	Financial Management Group
FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwife
HMIS	Health Management Information System
HMRI	Health Management & Research Institute
HR	Human Resource
HRD	Human Resource Development
HRIS	Human Resource Information System
HSC	Health Sub-centre
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In Patient Department
IPHS	Indian Public Health Standards
ISO	International Organization for Standardization
IUCD	Intra-uterine Contraceptive Device
JE	Japanese Encephalitis
JPHN	Junior Public Health Nurse
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana

LHV	Lady Health Visitor
LLIN	Long Lasting Insecticide Treated Nets
LR	Labour Room
LSAS	Life Saving Anaesthesia Skills
LT	Laboratory Technician
MB	Multi-bacillary cases
MCTS	Mother and Child Tracking System
MDR	Multi-drug Resistant (TB)
MIS	Management Information System
MHW	Male Health Worker
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MOIC	Medical Officer In-charge
MoU	Memorandum of Understanding
MPW	Multi-purpose Worker
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHSRC	National Health Systems Resource Centre
NICU	Neonatal Intensive Care Unit
NIHFW	National Institute of Health & Family Welfare
NIPI	Norway India Partnership Initiative
NPCB	National Programme for Control of Blindness
NLEP	National Leprosy Eradication Programme
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Suraksha Karyakram
NSV	Non-scalpel Vasectomy
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
PCPNDT	Pre-Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex-selection) Act - 1994
PHC	Primary Health Centre
PHN	Public Health Nurse
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PPP	Public Private Partnership
PRI	Panchayati Raj Institutions
PWD	Public Works Department
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RHFWTC	Regional Health & Family Welfare Training Centre
RHP	Rural Health Practitioner
RKS	Rogi Kalyan Samiti
RKSK	Rastriya Kishor Swasthya Karyakram
RMP	Rural Medical Practioner
RMSCL	Rajasthan Medical Services Corporation Limited
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojana
SBA	Skilled Birth Attendant
SDH	Sub Divisional Hospital
SHC	Sub Health Centre
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SIMS	Softline Intelligent Micro Systems
SNCU	Special Newborn Care Unit
SPMU	State Programme Management Unit
STG	Standard Treatment Guideline
TB	Tuberculosis
TNMSC	Tamil Nadu Medical Services Corporation Limited
VHND	Village Health and Nutrition Day
VHSNC	Village Health and Sanitation and Nutrition Committee

EXECUTIVE SUMMARY

The National Health Mission, (comprising of the National Rural Health Mission, launched in 2005 and the National Urban Health Mission, launched late in 2013) reflects a paradigm shift in the design and implementation of health programmes and policies. The NHM represents India's flagship programme for health systems strengthening. The decade long journey of National Health Mission so far is marked by significant gains, but complex health challenges remain. The annual Common Review Mission is an important mechanism enabling identification of such challenges. Nine CRMs (2007-2015) undertaken so far have provided valuable understanding of the results achieved, strategies which were successful and those which warranted mid-course corrections. The CRMs also enabled the identification of common problems and the possibility of scaling up context specific solutions across states.

The Tenth CRM was carried out in November 2016 (Nov 5 to 12) and covered 16 States. The Terms of Reference (TOR) for 10th CRM were developed by the Ministry of Health and Family Welfare (MoHFW) involving different stakeholders and technical experts from the programme divisions and covered various dimensions of National Health Mission ranging from service delivery to governance issues. This year the CRM included eleven TORs, focused on multiple aspects of the health system. The TORs also emphasized the implementation status of initiatives launched recently by the MoHFW. They include the Quality Assurance and Kayakalp award scheme, National Urban Health Mission (NUHM), Free Drugs and Diagnostics Initiatives, Health Systems approach to Human Resources, Rashtriya Kishore Swasthya Karyakram (RKSK), Pradhan Mantri Surakshit Matritva Yojana (PMSMY), Mothers Absolute Affection (MAA), National Dialysis Programme and Non Communicable Diseases (NCD) programmes. The broad objective of each TOR is to enable a rapid assessment of the key processes and outcomes of the various elements of the National Health Mission.

The members of the CRM teams included senior officials of MoHFW, representatives of the state governments (Health Secretary, Mission Directors, Directors of Health) Public Health experts from Civil Society Organizations and Academic Institutes, non-official members of Mission Steering Group of NHM having expertise in Public Health, experts from NITI Aayog, Development Partners and officials from related development sectors of the government like Social Welfare, Women and Child Development, etc. The team members were briefed on the objectives and methodology of conducting CRM by the senior officials and technical experts from MoHFW, and a similar process was undertaken at state level. Based on the findings of field visits, the teams compiled the key findings and recommendations. The state reports form the substance of the main report.

Key Findings

TOR1: Service Delivery : Reaching the Unreached

This TOR also focuses upon the status of infrastructure in public health institutions, access to and utilization of various services and key challenges observed during field visits. Recent initiatives that were a focus area for this TOR included review of progress in implementation of District Hospital (DH) Strengthening Free Drugs Service Initiative, Free Diagnostics Service Initiative, and Pradhan Mantri National Dialysis Program. Following are the key findings emerging out of various CRM state reports:

1. All States have reported relatively better adequacy

of health infrastructure as compared to previous Common Review Missions. Further, the number of health facilities functioning out of rented buildings have reduced markedly. However, significant shortfall in number of health centres is reported from Bihar (41% shortage in SHCs and 51% shortage in APHCs) and Nagaland (13% shortage in SHCs).

2. Time to care approach is yet to be institutionalized in most hilly States largely due to poor road connectivity and challenges related to inclement weather conditions in such remote areas.

3. All CRM States report improved utilization of services as compared to previous years. However, variability in performance amongst and within States persist. For instance, the institutional delivery (in public institutions) ranges from 27% (Kerala) to 80% (Tripura), OPD per thousand population ranges from 505.1 (Nagaland) to 4589.9 (Chandigarh), and IPD per thousand population ranges from 16.4 (Jharkhand) to 167.5 (Chandigarh). Further, challenges of underutilization of services remain in North Eastern States (e.g. Arunachal Pradesh and Nagaland).

4. All CRM States,, report having a Free Drugs Service Policy. However, Out of Pocket Expenditure (OOPE) on drugs was also observed to be incurred by patients in States like Bihar and Nagaland owing to poor implementation of the Free essential Drugs and Diagnostics Service Initiatives and mainly on account of challenges in supply chain management. In some States (e.g. Himachal Pradesh) OOPE on drugs is on account of limited number of drugs being included in the State Essential Drug List.

5. Andhra Pradesh, Gujarat and Madhya Pradesh have implemented pathology services under the Free Diagnostic Services program. PPP arrangements for provision of diagnostic services were also observed in Delhi, Himachal Pradesh and Jharkhand. However, considerable OOPE on diagnostics has been reported from Arunachal Pradesh, Jammu and Kashmir and Nagaland.

6. Digitalizing of indenting through electronic platforms such as e-aushadhi/Nirantar have been adopted in all CRM States barring Arunachal

Pradesh, Nagaland and Chandigarh. However, limited capacities of personnel in drug warehouses and procurement bottlenecks are leading to instances of stock-outs across multiple States and UTs (e.g. Arunachal Pradesh, Bihar, Chandigarh, Himachal Pradesh, Kerala, Nagaland and Tripura).

7. Under the Pradhan Mantri National Dialysis Programme, BPL populations have been exempted from user charges for availing dialysis services across all States. While most CRM States have reported availability of dialysis services in varying degree; Arunachal Pradesh, Jammu and Kashmir, Nagaland, Chandigarh, Kerala and Jharkhand are yet to operationalize dialysis services at district level through PPP mode.Some States where better progress was observed include Andhra Pradesh (11 centres), Bihar (17 centres), Maharashtra (30 centres), Himachal Pradesh (3 centres functional and tender floated for 6 more) and Tamil Nadu.

8. Jammu& Kashmir, Tamil Nadu, Himachal Pradesh, Tripura and Madhya Pradesh have initiated the process for strengthening of District Hospitals to develop them as training centers. However, many other States (e.g. Andhra Pradesh, Arunachal Pradesh, Delhi, Gujarat, Jharkhand, Kerala, Maharashtra, and Uttar Pradesh) have not reported any progress in this regard.

9. Availability of blood services have seen improvement in most States/UTs however in six States (Nagaland, Gujarat, Arunachal Pradesh, Uttar Pradesh, Jammu and Kashmir and Bihar) availability of blood has been reported as a concern, particularly at sub-district level. These States also report limited functioning of the Blood Storage Units either due to lack of trained human resources or non-linkage with a mother Blood Bank.

10. States/UTs reporting better functioning blood services are Tamil Nadu, Maharashtra, Andhra Pradesh, Chandigarh and Maharashtra. Where adequate blood is available, it was observed to be provided free of cost to pregnant women, while for other patients a charge ranging from Rs. 500 to Rs. 750 was levied (except in Tamil Nadu). Replacement happens to be the major source of procuring blood in most States.

11. Provisioning of AYUSH services have improved. However, in Andhra Pradesh, Arunachal Pradesh, Gujarat and Madhya Pradesh the provisioning of AYUSH service is inadequate at sub-district level. Further, it was observed that (across all CRM States) protocols for internal referral between the AYUSH and other departments are non-existent.

12. All States covered under the 10th CRM - except Jharkhand, Kerala, Tripura and Nagaland- now have call centers linked ambulance services. However, rational deployment of ambulances remains a challenge in hilly States like Arunachal Pradesh and Jammu and Kashmir. Further, the complement of equipment and human resources in Advanced Life Support ambulances is inadequate in many instances. With regards to training of Emergency Medical Technicians, most of the States -except Tamil Nadu and Maharashtra- have reported that the training of EMTs is not up to the desired level in terms of duration and knowledge retention.

13. All States except Delhi reported utilization of MMUs for outreach services. However, the degree of utilization varies across States because of poor planning, lack of human resources and weak IEC activities. Andhra Pradesh, Gujarat, Jharkhand, Maharashtra, Kerala and Tamil Nadu have reported better utilization of MMUs to provide health care services to tribal and marginalized population.

14. Almost all States visited in 10th CRM reported an intention to implement the Biomedical Equipment Maintenance Program as per Government of India Guidelines. Andhra Pradesh, Kerala and Maharashtra have implemented the Biomedical Equipment Maintenance Program. In Tripura, Nagaland and Arunachal Pradesh the tendering process has been completed, whereas Uttar Pradesh and Himachal Pradesh have released the RFP. Madhya Pradesh, Delhi and Tamil Nadu (where TNMSC is managing the maintenance) have completed the mapping of equipment. Gujarat, Jammu and Kashmir and Jharkhand are yet to implement the program.

15. Public Private Partnership arrangements that were observed as part of 10th

CRM included a) management of ambulance services (in Arunachal Pradesh, Bihar, Himachal Pradesh, Jharkhand, Madhya Pradesh, Maharashtra and Tamil Nadu), b) diagnostic services (Arunachal Pradesh, Andhra Pradesh, Delhi, Himachal Pradesh, Jharkhand, Tripura and Uttar Pradesh), c) dialysis services (Andhra Pradesh, Himachal Pradesh, Maharashtra), d) MMU services (Jharkhand, Maharashtra, Bihar and Tamil Nadu), e) management of health centers (Arunachal Pradesh, Andhra Pradesh, Gujarat, Nagaland and Tamil Nadu [Dental clinic]).

16. While all States visited under 10th CRM reported undertaking IEC and BCC activities at state, district and sub-district level; the States of Andhra Pradesh, Maharashtra, Tamil Nadu, Kerala, Tripura, and Himachal Pradesh were observed to be more organized and efficient in using this medium in improving the health service delivery to marginalized and tribal population.

17. Almost all the States visited under 10th CRM, have reported various best practices and innovative approaches to improve the quality of health care, reductions in costs and access to public health services. The range of observed best practices and innovations is wide and includes, a) e-initiatives, b) initiatives for community health volunteers (ASHAs/ Sahiyas), c) initiatives related to community empowerment, d) RMNCH+A program initiatives, e) measures to improve access to drugs, f) measures to improve access to health care, including primary care, AYUSH services, care for gender based violence and NCDs, f) financial protection and g) quality of care.

TOR 2: RMNCH+A

The objective of this TOR was to assess the planning and implementation of RMNCH+A strategy at all levels of service delivery, and review the implementation status of different RMNCH+A programmes/ initiatives. Focus was on reviewing the progress in RMNCH+A approach and Delivery Point harmonization, PMSMA, MAA, labor room practices, Dakshta training and RBSK. Following are the key findings emerging out of various CRM state reports:

1. States that were observed to have better planning of services under various components of RMNCH+A include Tamil Nadu, Gujarat and Delhi.

2. The challenges in RMNCH+A implementation were observed to be, a) inadequate orientation about the strategy in district officials (e.g. Arunachal Pradesh, Bihar, Madhya Pradesh), b) inadequate functionality of First Referral Units (e.g. Andhra Pradesh, where only 42% of the FRUs are functional), c) instances of inadequate availability RMNCH+A drugs and supplies at health facilities (e.g. Maharashtra, Kerala), and d) inadequate monitoring of RMNCH+A services (e.g. Madhya Pradesh, Nagaland).

3. In many states, antenatal care, particularly at the level of Sub Health Centers, the quality of Antenatal Care (ANC) was observed to be deficient either in terms of, a) range of services (e.g. Tripura, Nagaland, Kerala, Chandigarh, Jharkhand), b) identification and line listing of high risk pregnancies (e.g. Nagaland, Delhi, Tripura, Uttar Pradesh, Himachal Pradesh, Bihar, Arunachal Pradesh) and c) orientation on newer guidelines -such as those on Gestational Diabetes Management, Calcium supplementation,

deworming during Pregnancy, Screening for Syphilis/HIV- and protocols (e.g. Andhra Pradesh, Arunachal Pradesh, Himachal Pradesh, Kerala and Nagaland).

4. While States have initiated steps towards online payment of Janani Shuraksha Yojana incentives, the progress in this regard is relatively slow. For instance, in Andhra Pradesh only 5 districts (out of 13) have rolled out direct benefit transfer. In States of Himachal Pradesh, Maharashtra and Uttar Pradesh the payments are being conducted through account payee cheques. Further, instances of delay in payments have been reported in Arunachal Pradesh, Nagaland, Delhi (Shahdara), Madhya Pradesh (District Ratlam), Tamil Nadu (DH Namakkal) and Uttar Pradesh.

5. Services under the Janani Shishu SurakshaKaryakaram program have now been streamlined to a large extent. However, certain challenges that persist include, a) low awareness in tribal/vulnerable population groups (in Kerala, Jammu & Kashmir, Tripura, Maharashtra), b) lack of assured drop back services to postnatal mothers (in Uttar Pradesh, Andhra Pradesh, Chandigarh, Jammu & Kashmir, Delhi, Bihar, Gujarat, Nagaland), c) relatively lesser awareness about entitlements of infants and d) non-institutionalization of grievance redressal mechanisms.

6. States with relatively better mechanisms of maternal death review are Tamil Nadu, Maharashtra, Chandigarh and Gujarat. Tamil Nadu is also in process of establishing Maternal Near Miss Review.

7. All States, except Bihar and Nagaland, were observed to have initiated activities under the Prime Minister Surakshit Matritva Abhiyan. However, involvement of private providers was low in Chandigarh, Jammu & Kashmir, Delhi, Himachal Pradesh and Tripura. Providers were unaware about the MAA Mother's Absolute Affection) initiative in Arunachal Pradesh.

8. Community counselling for Infant and Young Child Feeding practices by service providers needs strengthening in Madhya Pradesh and Gujarat.

9. Maharashtra, Delhi, Madhya Pradesh, Gujarat and Himachal Pradesh reported issuing recently launched guidelines (such as use of antenatal Corticosteroids in preterm labour and use of Gentamicin by ANMs for management of sepsis) as well as implementing them at district and sub-district level.

10. Mortality rate in SNCUs ranges from 1-3% in Tamil Nadu to as high as 27% in Uttar Pradesh (Gonda District). Birth asphyxia, pre-maturity and neonatal sepsis have

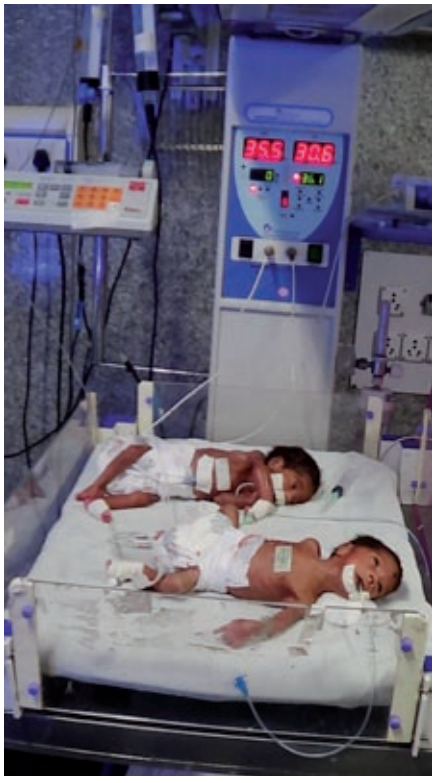
emerged as major reasons for admissions to SNCUs across various States. Some of the CRM States where shortages of new-born care facilities (particularly NBSUs and SNCUs) exist are - Arunachal Pradesh, Delhi, Madhya Pradesh, Bihar, Himachal Pradesh, Jharkhand, Kerala (District Idukki), Nagaland and Tripura.

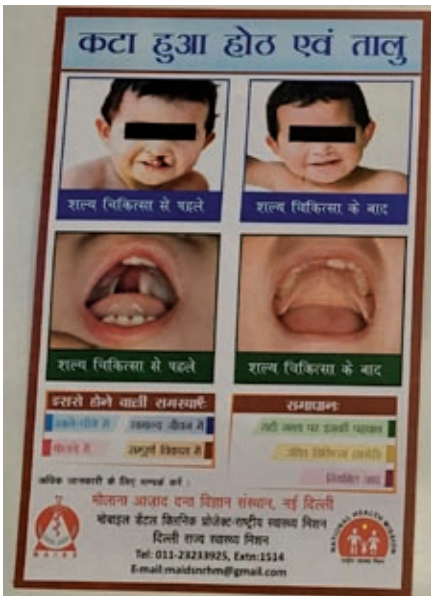
11. Maharashtra and Jharkhand were observed to have relatively better utilization of Nutrition Rehabilitation Centres (NRCs). Key concerns with respect to NRCs include; a) low bed occupancy rate (Andhra Pradesh, Arunachal Pradesh), b) non-adherence to guidelines (Chandigarh), c) human resource shortage (Delhi), d) limited linkages with Anganwadis (Madhya Pradesh, Uttar Pradesh), and e) low referrals from community (Andhra Pradesh).

12. Adequate supplies of ORS and Zn for diarrhoea control was reported in Andhra Pradesh, Chandigarh, Delhi, Gujarat, Jammu and Kashmir and Tamil Nadu. In Arunachal Pradesh none of the ASHAs or facilities that were visited had stock of ORS and Zinc tablets. Tamil Nadu reported progress in the implementation of de-worming programme in the State. Low uptake of iron folic syrup/tablets to children was reported from Andhra Pradesh, Chandigarh, and Nagaland. Uttar Pradesh reported stock-outs of iron folic syrup/tablets at the community level.

13. The implementation of the Rashtriya Bal Swasthya Karyakaram is underway in many states. In Delhi, District Early Intervention Centres (DEIC) are managed through NGOs. Progress was reported as being satisfactory in Tamil Nadu, Kerala, Tripura and Maharashtra. In Chandigarh follow up was identified as being a challenge, while vacancies in the RBSK teams were reported from Madhya Pradesh, Uttar Pradeshand Gujarat. Poor screening was reported from J&K and Nagaland. In Jharkhand and Uttar Pradesh DEICs referrals are a problem.

14. Arunachal Pradesh and Delhi are yet to implement child





death reviews (CDR) whereas, Madhya Pradesh has started CDR for deaths reported in SNCU.

15. IUCD and OCPs continue to be the mainstay of spacing methods being offered in public health facilities across all States and women continue to bear the burden of terminal methods of contraception. PPIUCD services are being offered in Andhra Pradesh, Arunachal (at district level), Chandigarh, Delhi, Gujarat, Himachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Nagaland, and Tripura., Shortage of supplies related to spacing methods, particularly condoms and OCPs were seen in Jammu and Kashmir, Jharkhand and Arunachal Pradesh. Follow up on family planning contraceptive users was inadequate in Bihar and Andhra Pradesh and follow up records were not maintained in these States. Involvement

of ASHAs in implementation of family planning services was good in Andhra Pradesh, Gujarat and Maharashtra and relatively limited in Arunachal Pradesh.

16. Comprehensive Abortion Care services were limited to District Hospitals in most States.

17. Routine Immunization (RI) services are improving across all States, with increase in use of IT enabled platforms such as eVIN, ANMOL, etc. Maharashtra, Gujarat, Jharkhand and Chandigarh have reported good planning and organization of VHND sessions. While in Himachal Pradesh ANMs were observed to be using due-lists generated from MCTS; in Andhra Pradesh, the due lists generated from ANMOL were used by relatively few ANMs. Microplanning of sessions needs strengthening in Andhra Pradesh, Madhya Pradesh, Jammu & Kashmir (Ramban), Nagaland, Arunachal Pradesh and Uttar Pradesh. Further, the mechanisms related to AEFI need to be strengthened in Himachal Pradesh, Jammu & Kashmir, and Madhya Pradesh (in terms of training of ANMs in identification, management & reporting of AEFI).

18. Underutilization of services provided at the Adolescent Friendly Health Centers was observed in Andhra Pradesh, Arunachal Pradesh, Bihar, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Kerala, Nagaland and Tripura. Moreover, the counselling services provided were observed to be limited to nutrition, Sexual and Reproductive Health and dermatological issues. There was also lack of visibility of IEC material related to adolescent health in the health facilities (except in Madhya Pradesh and Tamil Nadu). The peer education component under RKSK is yet to take off in any significant way.

TOR 3: Communicable Disease Control Programme

This TOR reviews the progress of implementation on the implementation of specific public health strategies, illness management and data use for various diseases control programmes and the extent to which they are integrated with other interventions of the NHM. Key findings are as follows:

1. Communicable diseases continue to be a major public health problem in India, but there is some good news. A consistent decline in malaria incidence has been observed, with a 40.8% decline in malaria related deaths. Similar declining trends have been observed in Kala Azar. There is progress in the elimination of Lymphatic Filariasis. The country has achieved the goal of elimination of leprosy (less than 1 case per 10,000 population) as a public health problem. However Chikungunya cases have been reported from 22 States and 3 UT's. JE continues to be a

challenge for the country and the high endemic districts in several States.

2. Operational surveillance units were observed across all States. The reporting of data on S, P and L form is being done in all States except in Bihar and Gujarat.

3. Inadequate IT infrastructure is an area of concern for infectious disease programmes in hilly areas.

4. All States except Maharashtra and Himachal Pradesh have shown significant progress in control of Malaria. However, increasing trends in the disease incidence in Maharashtra is a cause of concern and the state is considering inclusion of Malaria as a notifiable disease.

5. Increased incidence of Japanese Encephalitis (JE) cases was observed in Tripura and Andhra Pradesh and mortality due to JE was reported in Tripura and Uttar Pradesh. Coverage of JE vaccination was observed to be unsatisfactory in Bihar and Uttar Pradesh.

6. An increasing trend was observed in incidence of Chikungunya cases in Andhra Pradesh, Maharashtra, Tripura and Uttar Pradesh. The disease however, has recorded a declining trend in Tamil Nadu and no cases were reported from Bihar and Nagaland this year.

7. Overall declining trends of Kala Azar and zero mortality (due to Kala Azar) was observed in Bihar and Jharkhand.

8. The districts identified as high Endemic districts for Lymphatic Filariasis have not reported any new cases in Uttar Pradesh and Bihar. Special night clinics under Filaria control programme in high risk areas were observed to be functional only in Maharashtra.

9. In the Revised National Tuberculosis Control Program (RNTCP) the increasing trend of Multi- Drug Resistant (MDR) and Extreme Drug Resistant (XDR) cases is an area of serious concern. All the States visited during the 10th CRM have reported availability of Cartridge Based Nucleic Acid Amplification Test (CBNAAT) and co-location of TB HIV facilities in 63% public health facilities.

10. All the States have achieved desired Case Detection Rate of 80 per lac population per year. However, the States that have not achieved the cure rate of 90% include Andhra Pradesh, Bihar, Chhattisgarh, Haryana, Jammu &Kashmir, Jharkhand, Madhya Pradesh, Maharashtra, Tamil Nadu, and Uttar Pradesh. Sputum Conversion Rate after three months was found to be in the range of 80-90% in all CRM States. Adequate availability of anti TB drugs was observed in all the CRM States.

11. In leprosy, there is an increasing trend observed in Arunachal Pradesh (0.8). Though Tamil Nadu achieved the goal of elimination of leprosy, increasing trends of notification of child cases of leprosy was observed. Adequate drugs and diagnostic services were reported from all States. However, almost all States have reported shortages in human resources.

TOR 4: Non-Communicable Disease Control Program

The key objective of this TOR was to assess the implementation of various non-communicable disease control programs, and integration of NCD programmes with NHM. Key findings emerging from CRM state reports are as follows:

1. The National Programme for the Control of Diabetes, Stroke and Cardio Vascular Diseases is at varying stages of implementation across states. Reports indicate that Kerala and Tamil Nadu have a robust programme established in all facilities. The States/ UTs of Himachal Pradesh, Tamil Nadu, Maharashtra, Madhya Pradesh, Delhi and Chandigarh have taken steps to introduce NCD screening at various levels of facility

and are at different stages of implementation. Nonetheless all screening offered is opportunistic.

2. Functional NCD clinics with necessary infra-structure, human resources, drugs and diagnostics were seen only in Tamil Nadu and Kerala. Poor functionality was due to reasons such as delay in recruitments of specialists (Madhya Pradesh). NCD screening is restricted to women in Andhra Pradesh and in Uttar Pradesh. In Bihar, the NPCDS programme was reported to be non-functional, including the availability of equipment and drugs for hypertension and diabetes.

3. Examples of good practices observed in States (under the NCD program) include the tele-stroke project in Himachal Pradesh, where teleconsultation for stroke patients admitted in remote area facilities has made for better survival rates. In Tamil Nadu, the Amma Arokiya Thittam provides annual screening for all over 30 years of age for 25 parameters (for conditions such as anaemia, obesity, diabetes, hypertension, cervical, breast and oral cancers, refractory errors, cataract and skin conditions) in the 400 upgraded Primary Health Centres or at Block PHCs.

4. The National Program for Control of Blindness is being implemented in all CRM States, with screening activities being carried out at all the public health facilities in most of the States except in Jharkhand and Nagaland (due to shortage of specialists). Regular screening for refractive errors and distribution of free spectacles were observed in the States of Maharashtra, Madhya Pradesh, Tamil Nadu, Tripura and Uttar Pradesh. Tamil Nadu, Uttar Pradesh, Andhra Pradeshhave reported good integration of NPCB with the school health programme.

5. In general, the implementation of the various components of National Tobacco Control Program (NTCP) is sporadic and patchy. Maharashtra, Tamil Nadu and Kerala have implemented certain aspects of the initiative, but the holistic and robust implementation of NTCP, including IEC and awareness in community are lacking in almost all CRM States. Further, the integration between NTCP and NPCDCS is absent across all CRM States.

6. Tamil Nadu, Maharashtra, Madhya Pradesh and Gujarat have made progress in implementation of National Mental Health Program (NMHP) with high OPD footfalls, outreach camps, and dedicated screening & counselling rooms at facilities. Roll out of the District Mental Health Programme has been initiated in Delhi. Challenges in implementation of National Mental Health Program in other States include lack of community awareness, inadequate screening and referrals from peripheral health facilities, shortage of trained human resources (particularly specialists) and inadequate integration with other programmes e.g. RKSK.

7. There has been little progress in implementing the National Oral Health Programme in most States, except Himachal Pradesh. Its linkage with school health is weak and there are reports of irrational deployment of resources from Arunachal Pradesh and Tripura.

8. The National Programme for Care of the Elderly also has implementation issues though some districts in Gujarat (dedicated OPD time slots for elderly in OPD and distribution of mobility aids) Tamil Nadu and Kerala (available human resource as per norms and dedicated geriatric care centres) have made some progress in this area.

TOR 5: Human Resources for Health and Training

Focus of the 10th CRM under this TOR has been to review HR policy, systems in States to manage their human resources, training institutions and maintain

adequacy of human resources; along-with mechanisms for recruitments, performance appraisals and incentives for retention. Key findings emerging from CRM state reports are as follows:

1. Despite NHM augmentation of human resources in States, shortage of service providers exists in most of the States reviewed. This cuts across all cadres but is especially acute for specialists below the District Hospital level.

2. States are taking various measures to address service delivery gaps, viz. a) contracting specialists on-call (Chandigarh), b) appointing AYUSH MOs at PHCs (Bihar), c) providing non-financial benefits including mobility support, weekly-offs and fixed tenure postings to specialists (Andhra Pradesh) and d) relaxation in getting post-graduate seats to in-service MOs after completing rural area service (Andhra Pradesh, Bihar and Maharashtra).

3. Vacancies in administrative posts in Andhra Pradesh and Maharashtra and shortage of programme specific HR in Bihar and Gujarat were seen as bottlenecks in smooth implementation of national programmes in these States.

4. Integrated multiskilling of Laboratory Technicians have been done in Andhra Pradesh, Bihar and Kerala while Jammu & Kashmir intends to introduce this in future.

5. Lack of HR and infrastructure for training has resulted in sub-optimal training achievement in Andhra Pradesh, Chandigarh, Delhi and Kerala. No training has been conducted in Nagaland for the past two years.

6. Maharashtra's unique model of the College of Physicians and Surgeons that provides specialist training and legitimizes doctors to practice as specialist skill providers within the state, has been helpful in addressing specialist shortages in state.

7. Skill based competency tests are conducted in Arunachal Pradesh, Madhya Pradesh and Uttar Pradesh for identifying skill gaps of in-service staff but application of this measure for recruitment of skilled care providers was observed to be limited (existing in Bihar and Maharashtra only).

8. Irrational deployment of HR has been leading to low utilization of specialized skills (particularly EmOC and LSAS) in States like Bihar and Gujarat.

9. HRMIS is now implemented in many States including Bihar, Delhi, Gujarat, Himachal Pradesh, Maharashtra, Madhya Pradesh and Uttar Pradesh. Of these, Maharashtra and Uttar Pradesh have also developed Training Management Information System but it is yet to be linked with HRMIS.

10. Renewal of contracts of staff are linked with Annual Performance appraisal in Uttar Pradesh, Kerala and Tripura.

TOR 6: Community Processes and Convergence

The TOR for Community Processes and convergence broadly deals with key issues related to ASHA programme including selection,

training, support structure, incentive payments, progress made under NUHM and career opportunities for ASHAs. The TOR also covers the status of VHSNC, RKS and Community Action for Health. The key findings emerging in 10th CRM are as follows:

1. ASHAs are in place in all States except Goa, rural areas of Puducherry, and the non-tribal areas of Tamil Nadu. About 8.73 Lakh ASHAs are in position against the target of 9.46 lakh in rural areas (91%).

2. 34 out of 36 States/UTs are also implementing ASHA programme under the National Urban Health Mission (NUHM). Against the target of 70,721, a total of 42,769 ASHAs (60%) have been selected in urban areas. However, the issues related to low incentive payments and relatively higher rates of attrition need attention.

3. There has also been increasing ownership of the ASHA by the health system, and visualization of the ASHA as a key community resource valued for her facilitatory role. However, the other two roles perceived for ASHAs in terms of activist/social mobilizer and community care provider are yet to be fully realised.

4. There appears to be a strong positive correlation between the high training frequency and the knowledge and skill levels of the ASHA and ASHA training in four rounds of Module 6 & 7 has been completed in the States of Tripura, Nagaland, Manipur and Kerala. Training lags behind in all other States, notably Bihar, Uttar Pradesh, Andhra Pradesh, Jammu & Kashmir, Madhya Pradesh, and Maharashtra. Some States report attrition of trainers (e.g. Uttar Pradesh, Madhya Pradesh, Tripura, Andhra Pradesh). There is also a time lag between new ASHA selection and training, particularly in Delhi, Chandigarh, Uttar Pradesh and Andhra Pradesh.

5. Structures to support and mentor the ASHA exist in nearly all States. While several States have recruited new staff at district and block levels, the States/UTs of Andhra Pradesh, Delhi, Jammu & Kashmir, Himachal Pradesh, Tamil Nadu, Chandigarh and Kerala, use existing staff such as ANMs or District Public Health Nurses. However, vacancies in support staff at all levels were reported except in Uttar Pradesh.

6. Effective working partnerships between ASHAs and ANMs were observed in the States of Andhra, Nagaland, Jammu & Kashmir and Uttar Pradesh. This has resulted in improved coordination between the two frontline workers and facilitates service delivery. Jammu & Kashmir and Uttar Pradesh state reports also note effective functioning of the 'Triple AAA' platform, indicating convergent planning and action between Health and the ICDS department.

7. Most States are now providing both financial and non-financial incentives. Payment mechanisms have been reported as being

more streamlined from most States, with a majority of ASHAs having bank accounts. PFMS linkage is reported from Madhya Pradesh, Uttar Pradesh, and through RTGS in Jammu & Kashmir. Average monthly incentive amounts ranges from Rs. 2,350 in Jharkhand to Rs. 9,00 in Nagaland. Other incentives include – Uttar Pradesh providing mobile phones to all its ASHAs; mobile talk time to ASHAs in Upper Siang district of Arunachal Pradesh and Jammu & Kashmir; ASHA awards in Madhya Pradesh and Uttar Pradesh, and ASHA uniforms in Madhya Pradesh and Jammu & Kashmir. States such as Maharashtra, Kerala, Jharkhand, Bihar and Madhya Pradesh have provided insurance cover to the ASHA as part of social security schemes. Some States such as Kerala, Bihar, Tripura, Maharashtra and Jharkhand have made provision for preferential selection of ASHAs in ANM/ GNM training schools. The other avenue for career opportunity is to be selected as ASHA facilitator or Block Mobilizer (as is the case in Uttar Pradesh).

8. Grievance redressal mechanisms have been reported from Kerala, Andhra Pradesh, Madhya Pradesh, Maharashtra, Jharkhand, Delhi and Uttar Pradesh. However, most state reports (e.g. Andhra Pradesh, Delhi, Gujarat, Jammu & Kashmir, Nagaland, Tripura) indicate problems with availability and replenishment of drug and equipment kits of ASHAs.

9. In several States, the reports indicate that there is a need to improve the quality of skills of the ASHA. These particularly relate to nutrition, counselling for family planning, recognition of danger signs of pregnancy, and first contact care for sick new-born and children.

10. Most States have constituted over 95% of VHSNCs against their respective targets. The Village Health Committees formed as part of communitization in Nagaland before the launch of NRHM have been co-opted as VHSNCs under NHM. Reconstitution of VHSNCs was reported to be underway in Jharkhand and Chandigarh. However, reports regarding the functionality of VHSNCs give an impression that VHSNCs are not functioning as envisaged under the National Health Mission.

11. Timely fund flow was observed in Gujarat, Himachal Pradesh, Jharkhand and Kerala. Further,

high levels of convergence and strong panchayat system has led to pooling of resources of funds in Kerala which amounts to Rs. 25,000 per year for VHSNCs. However, issues related to VHSNC untied funds have been largely unresolved over the last few years in most States. The major challenges include delay in release of untied fund release, utilization and management of untied funds. For instance, the State reports of Andhra Pradesh, Arunachal Pradesh and Madhya Pradesh reflect that untied fund for the current financial year is yet to be released.

12. Mahila Arogya Samitis (MAS) have been formed in Andhra Pradesh, Gujarat, Maharashtra, Jammu and Kashmir (Anantnag district), Jharkhand, Nagaland, Tamil Nadu and Tripura while it is underway in Delhi, Bihar, Madhya Pradesh and Jammu and Kashmir (except Anantnag). However, MAS formation is yet to commence in Chandigarh, Kerala and Uttar Pradesh.

13. Rogi Kalyan Samitis (RKS) have been constituted in all States but the level of functionality was different across States on account of limited or no capacity building, delay in fund release and limited involvement of PRI representatives. The reports indicate that the RKS funds are predominantly being used for maintenance activities in most States. Only in Delhi, the fund is being utilized to set helps desks for patients and electric cart for patient's movement within the hospital premises.

14. Mechanisms to establish convergence with departments like WCD, SHGs, water and sanitation and PRI are weak across most States except in Andhra Pradesh, Chandigarh, Kerala and Gujarat.

15. Community Action for Health (CAH): The state of Maharashtra is much ahead in implementing activities under the Community Action on Health where the programme has been implemented in 14 districts. However, poor utilization of funds under Community action for Health was reported from most States. CAH has been recently rolled out in select districts of Arunachal Pradesh, Kerala, Madhya Pradesh and Tripura.

TOR 7: Information and Knowledge

The objective of this TOR is to assess the various Health Information Systems being used

in States and use of information for programme planning and monitoring. This section also reviews the implementation of telemedicine and of m-health solutions, availability of IT infrastructure and status of data reporting from the National Urban Health Mission. The key findings emerging in 10th CRM are as follows:

1. Facility wise reporting on Health Management Information Systems (HMIS) has stabilized in most health facilities (above 90%) in CRM States/UTs, except for Arunachal Pradesh (68%), Delhi (85%) and Gujarat (82%). Around 94% of facilities are regularly reporting into MCTS, which is now being replaced by RCH portal.

2. RCH portal is fully operationalised in most states visited (except Bihar and Nagaland). Chandigarh is planning to roll out integrated RCH registers. Though RCH portal has been launched in Arunachal Pradesh, the entry of data from health facilities is yet to commence.

3. Issues such as lack of standardized registers, lack of training and orientation on handling technology, poor internet connectivity and inconsistent power supply were reported, particularly from Arunachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Nagaland and Tripura.

4. Adequate availability of RCH registers was reported from most states. However, data discrepancies between recording registers and HMIS/MCTS/RCH portal was observed to be an issue in Arunachal Pradesh, Delhi, Madhya Pradesh, Maharashtra, Nagaland, Tripura and Uttar Pradesh.

5. Capacity building on HMIS/MCTS/RCH portal needs focus. Though some States like Jharkhand, Kerala, and Madhya Pradesh have been conducting refresher trainings, these are not on regular basis. Trainings related to the RCH portal has not been imparted at sub-district level in most of the States/UTs.

6. Except Jammu & Kashmir and Nagaland, all other States/UTs are using HMIS data (to variable extent) for preparing PIP, planning and monitoring.

7. Multiple e-initiatives, including health information and logistics management softwares, were observed to be functional in CRM States. Some of these include – ANMOL (in Andhra Pradesh), SNCU online (in Arunachal Pradesh), Computerized Accidents & Trauma Services and Hospital Management Information System (in Delhi), Telemedicine & Telestroke (in Himachal Pradesh), Ecman (Kerala), Chetna and EVIN (Madhya Pradesh), Matritva and EpiMetrics (in Maharashtra), PICME and National Oral Health Mobile app (in Tamil Nadu) etc. All these software work in silos and are often not interoperable.

TOR 8: Healthcare Financing

The objective of the TOR was to review the status of fund release and utilisation for activities under

NHM, examine the fund flow mechanisms and implementation of Public Financial Management System (PFMS), examine compliance with statutory requirements and document measures adopted to reduce Out of Pocket Expenditures (OOPE). The key findings emerging in 10th CRM are as follows:

1. So far as utilisation of funds are concerned, across the States that have been visited, reports indicate improvement in utilization of funds in almost all the States. States have also improved their capacity in financial management. The issue of vacancies in State finance HR that were repeatedly flagged in CRM reports of earlier years seems to have been largely overcome in most of the states visited barring a few such as Tripura and MP.

2. Most of the CRM States have put in place systems for transfer of funds through electronic transfers barring States in the North East like Nagaland and Arunachal Pradesh. However, delay in transfer of funds from State treasury to State Health Societies (SHS) continues to be a major problem with most states with delays ranging from 30-45 days in Gujarat, 40-42 days in Tamil Nadu, 88 days in Kerala to 75-90 in Delhi.

3. Barring Tamil Nadu none of the States were found to have allocated additional funds (at least 30% per capita) for HPDs. Allocation of funds have been found to be made based on utilisation of previous years. In most States, district RoPs have been disseminated barring Nagaland.

4. Fund utilization is particularly low under NUHM and NCD programs. Bihar has reported the lowest utilization of funds amongst CRM States under NCD programs.

5. As regards implementation of PFMS is concerned, while all States barring Nagaland has implemented PFMS, the progress of implementation shows it is at varied stages of implementation. HP and Tamil Nadu are states with 100% agency registration followed by Gujarat with 97%, MP with 95%, UP with 84%. Overall implementation of PFMS in Tripura is reported to be unsatisfactory throughout all the facilities as only 67% agencies have been registered under the PFMS portal with pendency at District and below level. As far as transfer of fund through PFMS portal, in Tamil Nadu, all the funds are being transferred from the State to the Districts and District to Sub District Level through PFMS. In UP, all the financial transactions including JSY beneficiary/ ASHA/Contractual staff/ Family Planning Schemes up to the CHC/PHC level are being done through the PFMS portal. In MP, payments towards ASHA incentive and JSY beneficiary are being paid through DBT using PFMS. However, reportedly, in Chandigarh has not only implemented online financial management through PFMS but also FMR generation through PFMS.

6. As regards untied grants, despite issue of guidelines for differential allocation of untied grants, none of the CRM states have reported adoption of differential financing of untied grants. Poor utilisation of untied grants is still an area of concern. In UP and

Chandigarh, there were sub centres with nil utilisation of untied grants. Kerala had not distributed the untied grants approved in 2015-16 to facilities while in J&K, fund disbursement to VHNCs has not been made from last 3-4 years. In HP, RKS funds were being utilised for programme expenses despite the programs having sufficient funds.

7. The all India performance audit for the period 2011-12 to 2015-16 by CAG completed in all States. The statutory Audit for 2015-16 was completed but final report awaited in most CRM States while it was under process in some states. Across States compliance of concurrent audit was found to be poor. It is observed that the auditors were not visiting the Block level facilities and were verifying the records at district HQ itself defeating the purpose of conducting the same. The Concurrent auditor for the F.Y. 2016-17 was not appointed in MP while compliance on the Statutory Audit and Concurrent Audit are not followed in J&K.

8. Amongst the 16 States/UTs visited during CRM, Andhra Pradesh, Arunachal Pradesh, Chandigarh, Bihar, Jharkhand, Uttar Pradesh and Maharashtra have not commented/ collected information on measures undertaken by the States to reduce OOPE. Similarly most States except Gujarat and Kerala did not report information on state health insurance programs. In Gujarat the awareness of RSBY program was found to be low and people were only aware about the state sponsored MA program.

8.1 Barring Tamil Nadu and Dehi, reports indicate some form of out of pocket expenditure by patients even in States like MP, Gujarat, Kerala, HP mostly on blood services, transportation and drugs. The cost incurred towards blood services range from Rs 300 to Rs 1500. Kerala has reported discontinuation of reimbursement of expenses to patients towards transport and diet under JSSK due to non-receipt of funds from July 2016.

TOR 9: Quality Assurance and Swachhta Initiatives

This TOR assess the progress in National Quality Assurance Program, Kayakalp Award Scheme, biomedical waste management and other quality related issues. The key findings emerging in 10th CRM are as follows:

1. Baseline Assessment of Facilities (Facility Assessment and Gap Analysis): Of the States visited under CRM, assessments have been initiated in 15 States (except Nagaland) but only five States namely Andhra Pradesh, Kerala, Uttar Pradesh, Gujarat and Maharashtra have developed a post assessment gap closure action plan. Common observation is that progress after Assessment/ Gap Analysis is slow in terms of prioritization of gaps, developing Action Plan, implementing measures of ensuring Quality Care, closing gaps and preparing facilities for certification.

2. Certification of Facilities: Out of total 16 States visited during CRM only two States namely Gujarat and Kerala have completed state certifications and three States have applied for national certification (Uttar Pradesh, Gujarat and Kerala).

3. Training and Capacity Building: Capacity building of all States visited during CRM- except Kerala and Chandigarh which have not conducted any trainings pertaining to NQAS and Kayakalp in FY 16-17- has been done both in NQAS and Kayakalp with the support of NHSRC.

4. Measures for ensuring Quality of Care at Public Facilities:

    a. Standard Operating procedures (SOP):In the visited CRM States SOP's were developed in the some of the facilities of only six States namely Uttar Pradesh, Arunachal Pradesh, Kerala, Gujarat, Jammu & Kashmir and Andhra Pradesh. However, interviews held with

health staff in these States revealed that they were not well versed with SOP's. In the state of Gujarat, the SOP's were developed centrally at the state level and were not customised as per the facility, making it non applicable in many places.

b. Measuring Patient Satisfaction Survey (PSS): Public health facilities in Bihar, Kerala, Tripura and Madhya Pradesh had developed forms for Patients satisfaction survey which were filled by the patients but no analysis of the filled forms were done. Gujarat PSS forms required to be translated in local language and Arunachal Pradesh conducted the last PSS at DH level in 2012. Only state of Delhi had completed patient satisfaction survey along with complete analysis. In rest of the States visited under CRM, PSS process has not been initiated.

c. Measuring Key Performance Indicators: Of the States visited under CRM, six States namely Madhya Pradesh, Andhra Pradesh, Gujarat, Kerala, Jharkhand, Maharashtra have started monitoring of key performance indicators. Andhra Pradesh has developed a dashboard and Jharkhand has started giving performance incentives to staff based on the indicators. Rest of the 10 States are yet to initiate reporting and analysis of KPIs.

5. Bio Medical waste Management: The revised Bio Medical Waste Management (BMW) Rules (28th March 2016) have yet to be implemented by the States. In majority of the districts visited, awareness regarding the new rules was minimal amongst the health staff. In Tamil Nadu, Himachal Pradesh and Jharkhand, a well maintained Bio Medical Waste Management System is in place according to BMW rules 1998. Disposal of Biomedical waste was a major concern in States of Arunachal Pradesh, Nagaland, Jammu & Kashmir and Madhya Pradesh as facilities visited were observed to burning the BMW waste.

6. Grievance redressal mechanism: Institutionalized mechanisms for grievance redressal was not evident in any of the CRM States. Often complaint boxes are seen to be having 'token' presence, and the boxes remained un-opened. Patients visiting the health facilities largely lacked awareness and knowledge regarding the grievance redressal mechanism.

7. Kayakalp: States are progressing well under the Kayakalp programme and since its launch in 2015 have shown considerable improvements in levels of cleanliness, hygiene and infection control in hospitals. Andhra Pradesh, Arunachal Pradesh and Himachal Pradesh have declared the Kayakalp awards. Gujarat, Madhya Pradesh and Maharashtra have finished the external assessments. The process of internal and peer assessment is still under progress in Bihar, Jammu & Kashmir, Delhi, Tamil Nadu, Jharkhand, Nagaland, Uttar Pradesh and Tripura and is not yet initiated in Chandigarh.

TOR 10: National Urban Health Mission

This TOR reviews the progress on operationalization of urban PHCs (UPHCs) and CHCs, utilization of services in these centres along with the status of community level mechanisms envisaged in the NUHM program. The key findings are as follows:

1. The process of mapping of vulnerable population is either underway or not yet initiated in most of the States, except in Gujarat where it has been completed. Most

States barring Nagaland, Andhra Pradesh, Arunachal Pradesh, Jammu & Kashmir, Kerala and Maharashtra have completed the GIS mapping. States are in different phases of completing the slum mapping.

2. Most States have strengthened State level institutional arrangements like establishing State Program Management Units, coordination & convergence committees and incorporation of additional members in the governing body under NUHM. However, the establishment of district level arrangements is still lagging. Convergence with Urban Local Bodies under NUHM requires more efforts as was observed in Delhi, Andhra Pradesh, Jammu & Kashmir, Maharashtra and Uttar Pradesh. On the other hand, Chandigarh and Kerala demonstrate good examples in terms of ULB collaboration.

3. Establishment of UPHCs within or nearby slum areas is still not being done in many States except in Delhi and Gujarat. New constructions or renovations of existing facilities is underway in most States. Acquiring land in crowded urban areas near slums was a major challenge cited by many States as a reason for delay in new constructions. Infrastructure of UPHCs was observed to be satisfactory in Chandigarh, Gujarat, Kerala and Maharashtra.

4. Availability and recruitment of human resources is also variable among States. States are struggling with issues of human resource shortage in some States and underutilization of recruited staff in others. Laggard pace of recruitments is owing to different reasons such as low salaries offered, reluctance to work during evening shifts, unavailability of trained personnel in smaller towns, and slow recruitment process at the state level. High attrition was observed mainly among medical officers, who join NUHM as a stop gap arrangement while waiting for admission to post graduate studies or for a better career opportunity.

5. Range of services provided by UPHCs is still limited with most States providing RCH services and not having incorporated services under the various Disease Control Programs. Kerala, Tamil Nadu and Chandigarh are a few States/UT providing NCD services at UPHCs. Irrational placement of equipment was also reported fromMaharashtra, Jharkhand and Madhya Pradesh. Delhi's Mohalla clinics demonstrated good utilization of services, although they have human resources deputed from previously well-functioning health facilities located elsewhere.

6. Most of the States have reportedefficient micro planning of UHNDs, However, irregular outreach activities were observed in Arunachal Pradesh, Jammu & Kashmir, and Delhi (due to pending approvals). In Andhra Pradesh, with the introduction of the e-Vaidya model, under PPP arrangements for running UPHCs there is a confusion regarding UHNDs.

7. Progress towards selection fo urban ASHA against targets was good in most states. Mahila Aarogya Samitis have been constituted in States such as Madhya Pradesh, Gujarat, Tripura and Andhra Pradesh, and their formation is underway in remaining States. However, Bihar and Chandigarh have been struggling with MAS formation; Kerala plans to use the existing Kudumbashree groups as MAS groups.

8. Delhi, Bihar, Kerala and Gujarat have constituted state, district and facility level committees for implementing Quality Assurance programme. Andhra Pradesh has started upgrading the UPHCs under the CM UPHC Initiative. Guidelines on quality assurance were not being implemented in some States including Maharashtra, Bihar and Uttar Pradesh. Compliance

to BMW guidelines was also inadequate in States such as Jammu & Kashmir, Delhi, Kerala, and Maharashtra.

9. Andhra Pradesh has outsourced the management of UPHCs to private partner Apollo, Chandigarh has entered into three different PPPs on different areas of service delivery (diagnostic facilities for MRI & CT, e- health centre and laboratory services). Gujarat, Maharashtra and Uttar Pradesh also have different PPP arrangements for service delivery and programme implementation.

10. Low expenditure is an issue common to almost all the States except Gujarat, Kerala, and Tamil Nadu. Apart from actual low expenditure, low utilization has also been a result of incorrect booking (as in case of Arunachal Pradesh), delay in formation of RKS for UPHCs and delay in transferring funds to them. RKS are almost non-functional in Jammu & Kashmir, and have not been constituted in Kerala and Madhya Pradesh.

TOR 11: Governance and Management

This section details the findings related to the functioning of the State and District Health Societies, functionality of Program Management Structures at state, district and Block levels, the use of data from monitoring and surveys for decentralized planning, convergence, and progress on implementation of key regulations such as the Clinical Establishment Act 2010 and PCPNDT Act:

1. Except in Gujarat, Delhi, Chandigarh, Kerala and Tamil Nadu, meetings of the State and District Health Societies are not being held regularly, indicating a lack of oversight and support to programme implementation.

2. While States such as Gujarat, Himachal Pradesh, Kerala, Tripura, and Maharashtra have initiated planning from village level, and resources allocations are based on decentralised planning, this was not seen in Andhra Pradesh, Arunachal Pradesh, Bihar, Jammu Kashmir, Jharkhand, Madhya Pradesh, Nagaland and Uttar Pradesh. Even a decade after implementation, decentralised planning and allocation of financial resources based on plans from district and sub district levels, is yet to take place.

3. In Madhya Pradesh and Maharashtra, clearly defined organogram and functions of various Programme Management Units are in place, with Job Descriptions of key staff. All program management staff under NHM (including those under NCDs) are now integrated into the State Programme Management Unit (SPMU) in Arunachal Pradesh, Gujarat, Maharashtra. In Gujarat and Jharkhand there is some effort at rationalizing of Human Resources.

4. Integration with the Directorate, is weak except in Tamil Nadu & Maharashtra. This is a key limitation at enabling an understanding of the health systems strengthening within the Directorate, and poses a challenge to in mainstreaming the activities of the Mission within the health department.

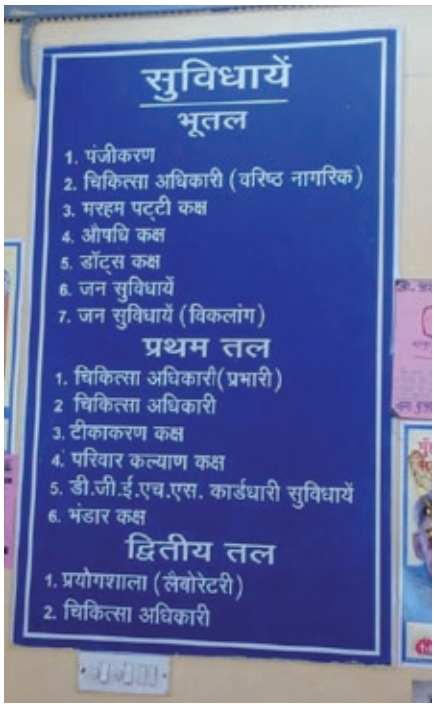
5. Convergence with related social sector departments such as Education, Sanitation, Urban development was observed in Gujarat, Kerala, Maharashtra, Jharkhand and Uttar Pradesh. Further, in these States the representatives of line departments were included in the State and District Health Societies,

and are actively involved in the RBSK, NUHM and immunisation programmes. Strong presence of Local Self Government in supporting the facilities (by contribution of funds for infrastructure, drugs etc.) and close monitoring of functionality has added a positive dimension in health care delivery in the state of Kerala.

6. The overall review and supportive supervision mechanism as per Government of India (GoI) guideline are weak across many States. However, state level supportive supervision team is proactive in the States of Gujarat, Himachal Pradesh, Bihar, Jharkhand, Maharashtra, and Tamil Nadu. Regularity in monthly review at all levels is observed in Kerala, Maharashtra and Gujarat. In Delhi, Kerala and Tamil Nadu corrective actions based on field visits were observed.

7. District level Vigilance and Monitoring Committees (DLVMC), (now named the DISHA committees- District Development Coordination and Monitoring Committees) as per GoI guidelines have been successfully reconstituted in Gujarat, Bihar, Jharkhand, Kerala, Maharashtra and Tamil Nadu.

8. Arunachal Pradesh, Bihar, Himachal Pradesh, Jharkhand and Chandigarh have notified State Clinical Establishment



(CEA) Act Rules. States/UTs of Delhi, Andhra Pradesh, Maharashtra, Madhya Pradesh and Nagaland are following state specific Act which regulates the private clinical establishments. States are attempting to align these acts with the key features of central CEA, 2010. No progress on CEA was noted from Gujarat, Tripura and J&K. In Tamil Nadu, progress has been stalled on account of a case filed by the state chapter of the Indian Medical Association.

9. The level of implementation for PCPNDT is poor in most states. Even where committees have been formed, reasons such as lack of witnesses, insufficient evidence, and out of court settlements are cited as major reasons for low conviction rates.

Recommendations

TOR 1: Service Delivery: Reaching the Unreached

1. Promoting procurement of generic drugs through robust agencies/societies dedicated for this purpose and increasing the number of drugs under Essential Drug List(s) are key steps that States need to undertake for reducing OOPE on drugs and improving access to drugs along with institutionalized prescription audit mechanisms.

2. States should prioritize strengthening of district hospitals with four basic specialties of Gynaecology, General Surgery, Anaesthesia and Peadiatritics and propose to develop these as training centers.

3. There is a need for supporting States in renewal of licenses and in roll out of online platforms for management of blood services. Greater coordination with private blood banks is also required.

4. Previous CRMs have recommended linking of AYUSH procurement with general procurement of other drugs and supplies. 10th CRM recommends the same with regards to procurement of AYUSH drugs and supplies. integration of AYUSH human resources in implementation of National Health Programs needs improvement.

5. Focus needs to shift towards ensuring quality emergency care in Advanced Life Support ambulances and building the capacities of emergency medical technicians. In States where the call center based ambulances are yet to be streamlined, there is a need to expedite the functionaling of call centre based approach or explore alternatives to ensure assured, timely and quality referralservices.

6. States must ensure that MMU routes are planned to cover areas where service delivery is unreachable either through health centers or outreach sessions. This must stay the cornerstone of MMU planning. In hilly States, particularly in North Eastern region, where one MMU per district is often inadequate, States may seek support for additional MMUs under NHM.

7. In States where the program has been already rolled out, the focus now should be on monitoring the quality of services provided by various private partners and ensuring that adequate grievance redressal mechanisms are institutionalized. States where tendering process has completed/in-process, must ensure that the inventory process is initiated and completed at the earliest.

8. PPP arrangements and Innovations in health programmes to strengthen health systems must be encouraged, monitored and followed up and viewed with the lens of professional objectivity, transparency and accountability of all involved stakeholders. States should undertake systematic reviews of PPP mechanisms with special emphasis on the design and management of the contracts between involved parties.

9. States needs to integrate IEC Cell created by NHM and Media Bureau or IEC/ BCC Bureau managed by Directorate Health and Family Welfare. Further, IEC in form of wall painting should be rationalized and other modes of IEC/BCC particularly local cultural groups involvement for influencing tribal and marginalized population groups behavior should be strategized in the plan.

TOR 2: RMNCHA

1. Principles of decentralised and differential planning need to be strictly adhered to while planning RMNCH+A implementation in States. This is vital in order to ensure availability of assured RMNCH+A services.

2. Facility specific road-map, along with SOPs for all procedures is required to be generated and effectively implemented. This includes establishing audit mechanisms, defined roles and responsibilities of service providers at all levels of care, and strict adherence to quality assurance guidelines.

3. Information generated from available sources and evidences generated from ground level must be utilized for effective RMNCH+A strategy planning and implementation. Strategic action plans such as State level new-born action plans should reflect information gathered from review mechanisms and operational & implementation research.

4. Newer initiatives such as PMSMA, MAA, etc. need to be better planned and implemented, along with strengthening the earlier initiatives for RMNCH+A health outcomes. States should explore possibilities of involving academic institutions, professional bodies and private sector to better implement these initiatives with wider participation of partners involved.

5. Strong linkages with community in planning and conduction of RMNCH+A programmes are missing and must be ensured by involving existing platforms and structures such as Village Health and Sanitation Committees (VHSNCs)/ Panchayati Raj Institutions (PRI), and Rogi Kalyan Samitis (RKS).

6. Training and capacity building of service providers needs to be taken on priority. This includes focussed attention on specific programmes such as RKSK and RBSK.

7. Integration and collaboration within ongoing RMNCH+A programmes, such as RBSK and RKSK, to expedite programme implementation must be considered by States.

8. Inter - departmental coordination between Departments of Health, Education and WCD has been a challenge and needs to be meticulously deal t with. There are many schemes/ initiatives such as WIFS, de-worming programme, etc. which can work effectively with better inter-departmental coordination and synergy of inputs.

9. Robust planning for fixed day family planning services is a must at all levels. States need to devise innovative approaches to ensure better coverage of family welfare schemes through community involvement.

10. Up-scale and replication of existing models of supply chain management for drugs & logistics should be a priority. Many States have IT platforms for managing supply chain which need to be adapted by others according to need.

TOR 3: Communicable Disease Control Program

1. All States reporting increased incidence and case load of malaria should scale up the activities under National Malaria Elimination Framework. Capacity building of first-line staff under various programs, particularly leprosy, tuberculosis and malaria must also be prioritized.

2. States must use the opportunities presented by initiatives such as Swacch Bharat Mission to streamline vector control measures and strengthen collaborations with municipalities and other local self-government bodies.

3. Adequate manpower under NLEP need to be ensured for disability prevention and medical rehabilitation.

4. There is also a need to utilize the platform of VHND through ANM/MPHW/ASHA for identification and referral of suspects as well as early case diagnosis.

5. Diagnostic facilities for the various spectrum of vector borne diseases must be made available at select sub-district facilities, particularly in high endemic areas.

6. Recommendations of previous CRM in terms of strengthening of entomological activities, death audits, recruiting adequate human resources need to be implemented.

TOR 4: Non-Communicable Disease Control Program

1. Augmenting NCD clinics particularly at sub-districts level is critical (particularly in Jammu & Kashmir, Gujarat, Jharkhand and Arunachal Pradesh).

2. Ensuring a robust supply chain mechanism of drugs, diagnostics and supplies to provide comprehensive access to NCD services is needed, as this has been identified as a gap in most CRM states.

3. Strengthen the referral mechanism of screened cases for appropriate confirmation of diagnosis, treatment & follow-up (particularly in Chandigarh and Jammu & Kashmir).

4. The active involvement of the community and engagement of frontline workers is essential for comprehensive management of NCDs and this must be encouraged with liaison and support from local community leaders.

5. Expand coverage of the NMHP through involving and ensuring services at facilities below DH.

6. Flexible norms and guidance provided by the GoI for recruiting specialists should be used by States to fill in the human resource shortage (particularly in Arunachal Pradesh, Andhra Pradesh).

7. Outreach activities should be planned and conducted at the district and block level regularly, and integration with RBSK and RKSK should be ensured for reaching out to children and adolescents in schools and in the community under the NMHP.

8. Ensure constitution of district tobacco control committee which meets regularly to review implementation of NTCP. These meetings should be documented with clear action points to ensure accountability.

9. Ensure stringent implementation of COTPA in districts through strengthening of current monitoring arrangements.

10. Build capacities within the public health system for cataract surgeries to accommodate the case loads, in addition to leveraging partnerships with NGOs and the private sector. The infrastructure and HR to deliver this should be strengthened as a priority.

11. The state needs to integrate the screening for cataract, glaucoma and other services within the general health system. Frontline workers should be actively involved in screening. Screening for cataract, glaucoma and refraction in public health facilities needs upscaling.

12. Integration of NPCB and NPCDCS for preventive check-up of diabetic retinopathy needs to be undertaken.

TOR 5: Human Resources for Health and Training

1. States need to expedite recruitments to fill existing vacancies. For this purpose, States may engage HR recruitment agencies empaneled at the national level under NHM.

2. Non-financial incentives including relaxation in higher education for doctors serving in rural areas, other benefits including mobility support, weekly off days and fixed tenure postings to specialists have shown to be helpful in attraction and retention of HR and may be scaled-up.

3. Alternate models for generation of specialist skill providers such as College of Physicians and Surgeons and fast-tracking of specialization courses such as DNB should be considered for addressing the shortage of specialists in States.

4. Preference for in-service NHM staff in recruitment for regular positions (as undertaken by Andhra Pradesh) may be explored by other States too.

5. Integrated multiskilling of LTs and Counselors and utilization of their services across the programmes as undertaken by some States is a welcome initiative and may be adopted by other States too.

6. Human Resource Management Information System (HRMIS) should be established in all States to facilitate in HR planning and the rational deployment of human resources.

7. Training Management Information System (TMIS) should be set-up and linked with HRMIS for assessing training needs, facilitating in planning and monitoring training progress in States.

8. Robust performance appraisal systems, which objectively take into account employee's performance and are linked with renewal of individual employee contracts, should be adopted.

9. Creation of a separate Clinical and Public Health cadres with well-defined career pathways has proved to be a useful step towards improved public health outcomes, better role allocation and work satisfaction among staff. The Government encourages States to adopt this.

10. Strengthening training institutes with requisite faculty and infrastructure is required to ensure quality and the smooth implementation of training programmes.

TOR 6: Community Processes and Convergence

1. Implementation experiences of the past decade, require that the community processes component - not only in urban areas but also in rural areas- now needs a design modification, to enable integrating it within comprehensive primary health care. This will provide an additional mooring for the programme, enabling the ASHA to function as a member of the frontline worker team, and facilitate the implementation of the promotive, preventive, rehabilitative components of primary health care.

2. Given the experience of the past several years, States should now undertake a mapping exercise to assess gaps and prioritize selection only in such areas where there are vulnerable and marginalized populations. States should also assess population coverage of the ASHA and ensure that there are no missed out households.

3. Non-high focus States now need to factor in the changing epidemiologic and disease patterns and project newer roles for ASHA. One direction in which this can be undertaken is to build on the comprehensive primary health are rollout announced by the MOHFW. ASHA should be considered a part of the frontline worker team.

4. ASHA training in Module 6 and 7 needs to be expedited so that ASHA may be equipped for other roles. This is also a pre- requisite for Level 1 certification.

5. Given that several indicators related to RCH have improved, States now need to realign their incentive structures and correlate them with the revised roles of the ASHA. This will require extensive consultations with district and sub district stakeholders including, most importantly the ASHAs themselves.

6. States need to expedite selection and training in urban areas under the NUHM. The NUHM offers an opportunity to immediately link the ASHAs as members of the primary health care team. This will require a review of roles and incentives.

7. For VHSNC and RKS, a key step to ensuring functionality is to build the capacity of the members and create systematic training structures as was done in the case of the ASHAs. The active engagement of Panchayat Raj Institutions is required and States should consider leveraging the capacity building funds awarded to Gram panchayats under the 14th Finance Commission.

8. The RKS requires to be strengthened as an accountability structure for quality of care. The current push for certification and accreditation under the Quality assurance framework, should engage proactively with RKS members to leverage mutual objectives and to strengthen the RKS as a mechanism to sustain the quality standards.

9. Given the myriad concerns with release of untied funds and the state findings of the multiple yet seemingly ineffective use to which funds are put, the process for release of untied funds for VHSNC, MAS and RKS need to be reviewed and streamlined. States should consider leveraging GP funds as Kerala has done.

TOR 7: Information and Knowledge

1. There is an urgent need for institutionalizing the data verification practices such as strengthening the cross validation of data by a supervisor before being uploaded to the portal and ensuring reporting from private sector on HMIS.All the UPHCs should be mapped and encouraged to start reporting on HMIS.

2. Regular and refresher trainings for data utilization for different levels of staff like ANMs and DEOs is needed.

3. Integration and interoperability of different available information systems need to be looked into by developing integrated health information exchange platforms.

4. There is a need for convergence of health and different departments in development sectors like Tribal, Woman and Child, Education and Water and Sanitation etc. to aid in comprehensive planning at State/UT and district level for better health service delivery.

5. Alternative methods like VSAT, data cards, etc. for providing reliable internet connectivity and generators/ solar power/inverters etc. for power supply need to be strengthened.

6. Telemedicine projects should be developed and extended to areas with difficult topography and limited resources.

TOR 8: Healthcare Financing

1. Recruitments and capacity building of finance and accounts personnel needs to be addressed on a priority basis by States for better financial management and accounting practices.

2. The flexibility in diversion of funds between pools should be considered strictly as a contingency measure by States to fill immediate requirements.

3. States need to avoid carrying transactions from a single account. Separate bank accounts should be created for different programmes such that there is a transparency and accountability in the use of funds for these programmes.

4. States need to allocate funds to High Priority Districts as per norms.

5. To avoid delays in transactions, States have to address the issue of bank integration and ensure synchronisation.

6. Settlement of long standing advances and unspent balances have to be addressed as a priority by States to avoid differences between the balances shown in books of district and sub-district level accounts.

7. States need to maintain a computerised stock registry of medicines to ward off differences in the list of stock of medicines available in the stock register and the actual count of medicines at the facilities.

8. Untied funds should be utilised by States to purchase essential drugs and maintenance of health facilities to deflect financial crunch.

9. States need to examine reasons for high Out of Pocket Expenditures and make arrangements for free availability of drugs and diagnostics and transportation of patients using the public health facilities.

10. States need to initiate the process of institutionalisation of State Health Accounts by creating a budget head, providing a budget and appointing a Nodal Officer in-charge for SHA.

11. Better information need to be collected regarding the functioning of the state insurance schemes and RSBY. There seemed to be low awareness about RSBY in Gujarat.

TOR 9: Quality Assurance

1. States need to expedite the recruitment of HR for the Quality Assurance units and operationalize the already constituted state and district quality assurance committees by conducting regular review meetings at state and district levels.

2. Trained HR available with the state should be used to conduct internal assessments of health facilities and provide inputs to close the gaps.

3. States should prioritise the identified gaps and develop time bound action plans. Efforts should be made to close the gaps and preparing facilities for National certification.

4. Since it is the second year of implementation of Kayakalp, States should now focus on improvements from the previous year in cleanliness of the facilities and infection control, as it is one of the major factors which influence patient satisfaction.

5. States should orient health facility staff on the new revised rules of Biomedical Waste Management2016 and help the facilities in implementation of the new rules. Strict actions should be taken against burning of the biomedical waste.

6. States should focus on infection control activities and regularly engage in trainings pertaining to hand hygiene practices, use of personal protectiveequipment,isolation precautions, sterilization, cleaning and disinfection practices and follow up on the impact of such trainings.

7. States should not only conduct regular Patient Satisfaction Surveys as per the guidelines but also follow up on action points emerging from the analysis of such surveys.

8. Grievance Redressal Mechanismgoes a long way to ensure patient-centric care and restore trust of the community in health system. Hence States should set up a robust grievance redressal mechanism in terms of installing Complaint/ Suggestion Box, Dedicated Helpline or holding Open meetings etc. All complaints need to be resolved within a stipulated time-bound manner and feedback provided to the complainant.

9. Periodic and regular Prescription audits, Medical and Death auditsshould be carried out at all levels of health facilities followed by analysis with corrective and preventive actions based on findings.

10. Internal and External Quality Assurance Program activities specially in terms of conducting internal assessment at periodic intervals, mock drills (for Fire and other disasters), validation of lab tests, calibration of equipment, monitoring of radiation exposure by TLD badges etc. need to be carried out on regular basis.

11. The States should ensure AERB approvals for setting up and operationalizing Radiology treatment and diagnostic centres.The X-ray departments of the facilities including Portable X-Rays and C-Arm need to be realigned as per AERB guidelines as it will help in preventing radiation hazard.

12. Standard Operating procedures (SOP's) are responsible for maintaining uniform process throughout the facility and adherence to the protocols in case of ambiguity. It is suggested that state should develop easy to understand, crisp SOP's in vernacular language and follow up on their implementation.

TOR 10: National Urban Health Mission

1. Institutional arrangements such as establishment of state, district and city level implementing teams must be put in place as the first step to streamline NUHM implementation.

2. GIS mapping of facilities and household based surveys may also be conducted, if resources permit. Facility based HMIS reporting should be started for all UPHCs.

3. States must continuously engage ULBs through sensitization to uptake their respective role in NUHM implementation, with continuous support from the state.

4. UPHCs must expand their range of services from only RCH to include all National Disease Control programmes. Population based NCD screening should be an essential component of the services provided by all UPHC, with follow up and drug dispensation.

5. Establishment of Rogi Kalyan Samitis and Mahila Aarogya Samitis and release of funds to them should be expedited

as it is a major reason for low utilization of funds.

6. States must identify the specific causes of low recruitment, attrition and administrative delays in recruitments and ensure that all sanctioned positions are filled. State must ensure rational deployment of HR at the UPHCs.

7. State needs to organize appropriate capacity building and orientation sessions for the DPMs and District Urban Health Coordinators on City Health Planning, Mapping and Listing while the ANMs and ASHAs need to be oriented on vulnerability mapping.

8. The MoUs for PPP arrangements must define the responsibility of the private partner, develop a framework to monitor performance of PPPs including defined time bound deliverable and measurable outcomes.

TOR 11: Governance and Management

1. Thelackofintegrationbetween NHM and Directorates at state levels requires an assessment of problems faced in various states. Bottlenecks need to be identified and common solutions need to be proposed.

2. States should make a renewed push to revitalize district and sub district planning, based on local epidemiology and burden of disease. This will necessitate capacity building of block, district and state programme management programme units particularly with regard to the use of data in planning and an understanding of actions for social and environmental determinants of health.

3. States must ensure involvement of other departments in preparing district action plans/district PIP since many activities under health are cross cutting and can be implemented by the better expertise of the concerned departments.

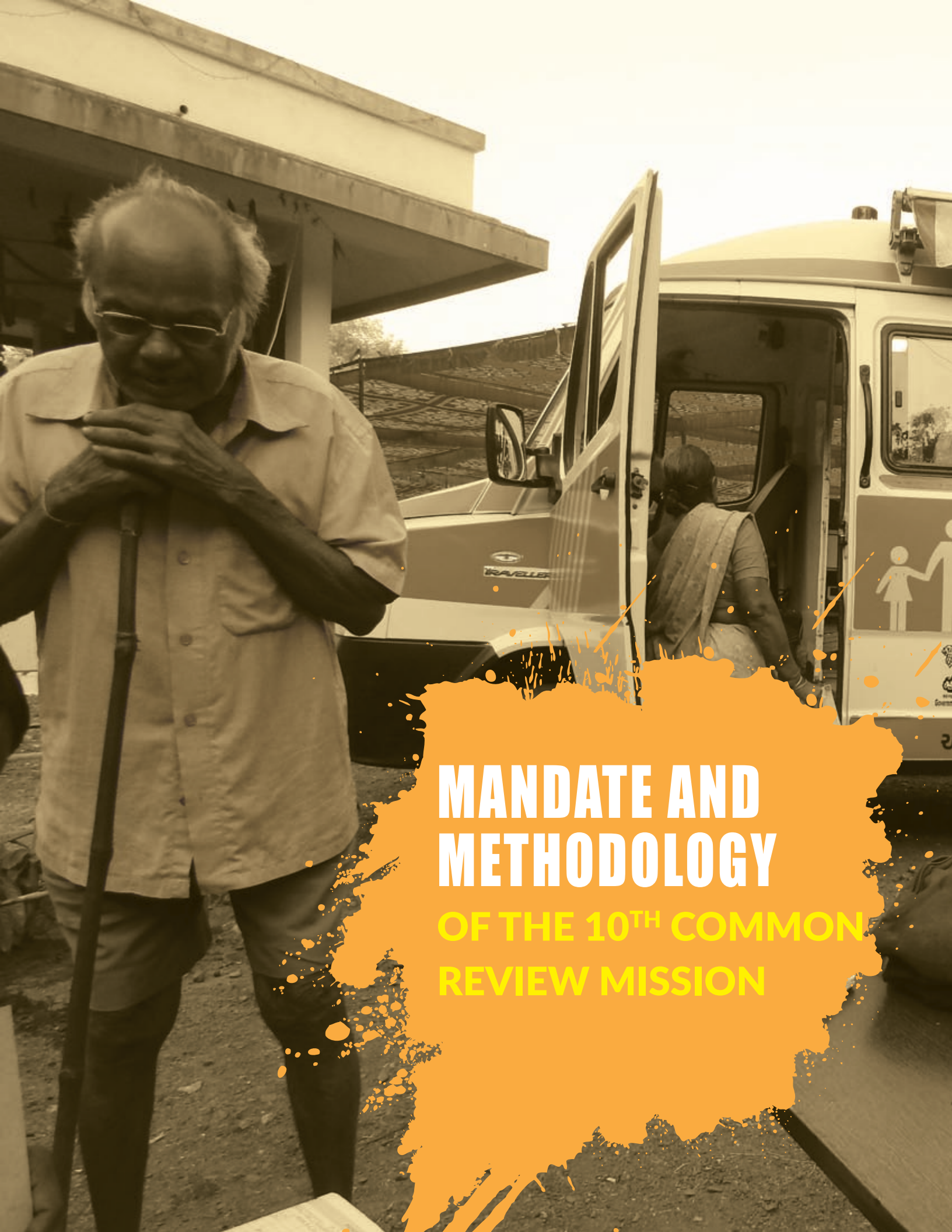
4. All ULBs and Panchayat representatives should also be oriented on the programme and policies of NHM so that they can also do informed supportive supervision of the health facilities.

5. State Health Mission and District Health Mission members' participation helps in improving and accelerating the various initiatives under NHM. Hence an adequate orientation and advocacy with the chairmen and the members needs to be undertaken to realise the shared vision of NHM.

6. District Collector's orientation in NHM activities and various governance mechanisms must be undertaken by all States.

7. States need to expedite the formulation of the Rules and begin implementation of the CEA, as a means to regulate private clinical establishments for improved quality of care.

8. An enhanced focus on implementing PCPNDT act, with a concomitant effort to sensitize communities and service providers alike on the causes and consequences of poor child sex ratio (CSR) and the provisions of the Act. A priority for such communication efforts would be those blocks and districts where CSR is low.



MANDATE AND METHODOLOGY

OF THE 10TH COMMON REVIEW MISSION


NATIONAL RURAL HEALTH MISSION
SUB-CENTRE
AYENG
DIST : EAST-SIANG
Govt. of Arunachal Pradesh
RKS Registration No :SR/ITA-
NYC

MANDATE AND METHODOLOGY
of the 10TH Common Review Mission

The National Rural Health Mission was launched in 2005 with a mandate to address the health needs of underserved rural areas. The programme was further strengthened under the ambit of National Health Mission with inclusion of National Urban Health Mission as a submission in May 2013. The focus on covering rural areas is continued along with inclusion of non-communicable diseases and expanding health coverage to urban areas. The previous Common Review Missions have provided valuable insights and understanding of the strategies which were successful and have led to several significant mid-course adjustments. The Tenth Common Review Mission (CRM) is of special importance as it was undertaken after completion of tenth year of NRHM implementation. The 10thCRM TORs focused on assessing implementation status of new initiatives and guidelines issued by Ministry of Health and Family Welfare in terms of progress towards Free Drugs Services Initiative, Free Diagnostics Services Initiative, Pradhan Mantri Free Dialysis Initiative, along with keeping continuous focus on Kayakalp award scheme for public health facilities, RKS guidelines, National Urban Health Mission, operational guidelines for enhancing performance of multipurpose worker (female), Rashtriya Kishor Swasthya Karyakram (RKSK) and progress on NCD programme.

The broad objectives of 10th Common Review Mission

1. Review the progress of NHM implementation:
    a. As against set goals and objectives related with IMR, MMR, TFR and goals related with various disease control programs
    b. In terms of its impact on accessibility, equity, affordability and quality of health care services
2. Review implementation status of new initiatives and guidelines issued by MoHFW in terms of following:
    - Progress towards Kayakalp award scheme for Public Health facilities
    - Rogi Kalyan Samities (RKS) Guidelines
    - Progress made under National Urban Health Mission
    - Free Diagnostic Service Initiative
    - Free Drug Service Initiative
    - Operational Guidelines for Enhancing Performance of Multipurpose Worker (Female).
    - Rashtriya Kishor Swasthya Karyakaram (RKSK)
    - Progress on NCD programme
3. Review the extent of compliance to recommendations made by earlier CRMs.
4. Review the progress and the State's response to conditionality and issues related to non-compliance.
5. Review the progress in addressing critical issues in health systems by lead Development Partners in the State specifically in context of HPDs.
6. Document good practices and innovations identified by the State.

7. Make recommendations to improve programme implementation and design.

Geographic Coverage of 10th Common Review Mission

The 10thCRM covered a total of 16 States/UTs, including 9 High Focus States including 3 North-Eastern States,5 Non- High FocusStatesand 2 UTs. The States were selected with a view to provide a representative picture of the progress made under National Health Mission (NHM).

The States/UTs covered under 10th CRM were Arunachal Pradesh, Bihar, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Nagaland, Tripura and Uttar Pradesh, Andhra Pradesh, Chandigarh, Delhi, Gujarat, Kerala, Maharashtra, Tamil Nadu. In each state two districts were selected based on service delivery indicators – of which one was good performing and another an under performing district.

Composition of teams for 10th Common Review Mission (Annexure 1)

Each State was visited by a 15-17member team comprising of the following:

- 5-7 Government Officials
- 2-3 Representative from Public Health Institutions
- 2 Representative of Development Partners
- 1-2 Representatives of Civil Society
- Consultants of various divisions of the Ministry

On 4th November, 2016 all the participants were briefed on the objectives of 10th Common Review Mission. During this briefing, teams were provided with a detailed Terms of Reference for the visit, including checklists. The TORs were divided among team members according to area of expertise. Team members were expected to submit observations on these within a specified time frame. The state reports would be a compilation of the findings of each TOR.

Timeline of 10th CRM

The 10th CRM started on 4thNovember and ended on 11th November, 2016, (10th November to 15th November, 2016 for the States of Bihar and Jharkhand) with a National level briefing workshop at New Delhi. Teamsreceived a briefing session by State officials before initiating district visits andthe visits were concluded with State debriefings in the respective State capitals.

Terms of Reference for the 10th CRM

TORs of the 10th CRM cover 11 components which are to be reviewed by CRM team-members. Further, there were certain focus areas under the current review mission and these have been mentioned along with respective TORs.

1. Service Delivery: Reaching the Unreached *(DH Strengthening, Free Drug Initiative, Free Diagnostic Initiative, Pradhan Mantri National Dialysis Program)*

2 RMNCH+A (RMNCHA *Approach and DP Harmonization; PMSMA; MAA; Labor room practices and Dakshta Training; RBSK-Screening at Birth, Screening in AWC & follow-up)*

3 Communicable Disease Control Programmes *(Private sectorinvolvement inTB control, especially TB notification fromprivate sector)*

4. Non- communicable Disease Control Programmes *(Progress on NCD Programs)*

5. Human Resources for Health and Training *(Health Systems Approach to HR)*

6. Community Processes and Convergence

7. Information and Knowledge *(Data utilization for*

programme planning and monitoring)

8. Healthcare Financing

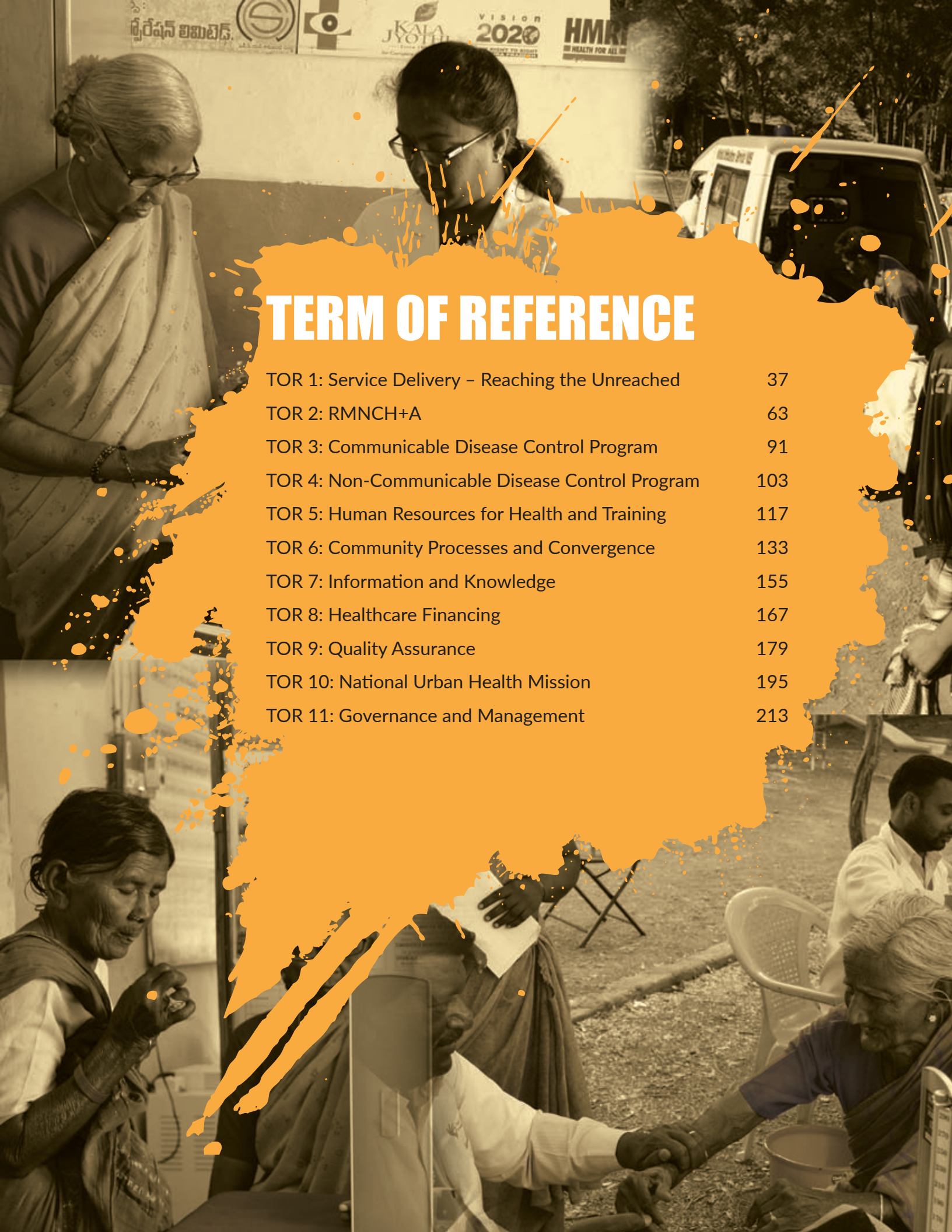
9. Quality Assurance *(Quality Assurance & Kayakalp Award Scheme)*

10. National Urban Health Mission *(Progress made under National Urban Health Mission)*

11. Governance and Management

The National report contains an analytical review on each of these themes and summary of key findings from the respective state reports. It also contains recommendations and state specific findings. The report also presents some of the good initiatives and innovations currently in practice at ground level.

While discussing each theme we first present the 10th CRM theme wise objectives, then an analytic summing up of the observations from across all 16 States and the recommendations. This is followed by a brief summary of findings on that theme from each state. An effort has been made to capture the richness of the state reports and include as many observations as possible.



TERM OF REFERENCE


LABORATORY ROOM

TOR 1 | SERVICE DELIVERY
Reaching the Unreached

OBJECTIVES

- To review the adequacy and functionality of health infrastructure in terms of population norms, their accessibility as per time to care norms (hilly and desert areas), progress of infrastructure works and utilization in terms of service delivery
- To oversee the health system strengthening components with a focus on drugs, diagnostic services, blood services – Blood Banks/BSUs, dialysis services, inventory mapping and comprehensive maintenance of bio medical equipment, integration with the AYUSH services, ambulance services, Mobile Medical Units, public and PPP mechanisms if any.
- To review the extent, reach, quality, visibility, availability and effectiveness of IEC material and their use, use of IT based IEC/BCC initiatives such as SMS, pre-recorded voice calls, Interactive Voice Response System, m-health.

National Overview

Investments in the infrastructure development under the aegis of National Health Mission have positively affected the physical access to healthcare. There is an increase in various levels of infrastructure (6.19% SHCs, 9.11% PHCs and 64.67% CHCs) as compared to the baseline year 2005. Inspite of surplus infrastructure in many States, the country still has a shortage of SHC (20%), PHCs (22%) and CHCs (30%). This indicates that infrastructure development (particularly in States with relatively higher degree of shortages in health infrastructure such as Bihar, Jharkhand and Uttar Pradesh) remain a priority for coming years. A marked area of improvement has been reduction in number of health centers functioning out of rented buildings. For instance, in 2016 only 21.23% of SHCs were in rented buildings as compared to 34.47% in 2005. Despite these infrastructure improvements, access to care during the 'golden hour' remains a challenge in the country, particularly so in the hilly areas.

The NSSO 71st Round reports a large portion of population availing services from public sector. The share of Public hospitals in child birth has increased to 56% in 2014 from 13.1% in 2004-05 showing an increase of more than 300%. The share of public hospitals in child birth in urban areas has

also increased from 21.5% in 2004-05 to 42% in 2014-15. Compared to an OPD per 1000 rate of 218 (in 2008-09), in the year 2015-16 this rate stood at 1033. Similarly, IPD per 1000 population has increased from 24.07 (in 2008-09) to 48 in 2015-16. Similar increases have been recorded in the major surgeries rate which has shown a jump from 42 (per 1000 population in 2008-09) to 363 per 1000 population in 2015-16. While RCH services have now been largely streamlined, the emerging challenge is provision of NCD services on a continuous and assured basis. The availability and preference for private facilities is also reported. A critical reason for preference of private healthcare facilities is non-availability of 24X7 care in public hospitals. For instance, only 8.9% of total PHCs and 25.7% of CHCs function on 24X7 basis.

Measures to ensure availability of free drugs and diagnosis has been initiated across all States, some of which were initially part of packages such as Janani Shishu Shuraksha Karyakaram, supplemented by National Free Drugs Services initiative and Free Diagnostics Services Initiatives etc. As per the observations of current CRM, the out of pocket expenditure on drugs has now substantially reduced in high priority States like Uttar Pradesh and Madhya Pradesh. Way forward in ensuring better availability of drugs is to ensure a more robust monitoring of procurement systems, supply chain management, institutionalizing rescription audits etc. States should seek support for scaling up of IT platforms such as e-Aushadhi and ensure generic drug prescription by providers. On diagnostics, there needs to be a movement towards an Essential Diagnostics Package that is to be provided as a bare minimum across all States.

Country now has 2,608 blood banks and 696 functional blood storage units. Newer initiatives in this regard include online systems linking blood banks within States. However, limited access to blood persists as a challenge, particularly in States that have limited human resources. Observations emerging from 10th CRM in this area are discussed later.

A total of 17,449 health facilities (9.4% of total public facilities) have co-located AYUSH services. Of these health facilities, 47% are in high priority States (including those in NE region). However, erratic availability of AYUSH medicines and supplies continues to be a challenge and needs further attention. Rashtriya Bal Swasthya Karyakaram remains the program involving maximum number of AYUSH human resources and has employed about 14 thousand AYUSH doctors.

Before the inception of the NRHM, call center linked public ambulances were non-existing. A total of 22,164 ambulances are operational under the National

Health Mission. Of these 34% are Dial 102 ambulances, 34.5% are Dial 108, 2.7% are Dial 104 and 27.9% are patient transport vehicles. 335 districts across India now have Mobile Medical Units to cater to populations in remote and difficult areas. Of these 58% districts are in high priority States. Further 45% of the MMUs are operational in high priority districts in the country. However, challenges related to inadequate planning of MMU services, including route and site plans, persist in several States (e.g. Arunachal Pradesh, Bihar, Jammu & Kashmir, Madhya Pradesh, Nagaland and Uttar Pradesh).

Under the Biomedical Equipment Maintenance Program, the functionality of 7,56,750 medical equipment in 29,115 health facilities were examined costing approximate Rs 4,564 Cr. Equipment of approximately Rs 400 Cr. became functional within 4 months in 12 States under the Biomedical Equipment

Management and Maintenance Program.

Every year about 2.21 lac new cases of End Stage Renal Disease (ESRD) get added in India resulting in additional demand for 3.4 crore dialysis per year. With approximately 4950 dialysis centres, largely in the private sector, the demand is less than half met with existing infrastructure. To improve access to dialysis services the Pradhan Mantri National Dialysis Program was launched in PPP mode for ensuring free dialysis services to poor at District Hospitals. The Programme is yet in its nascent phase, however all States report an initiative in the direction of providing free dialysis services to the poor (at least in one public health facility per district).

Public-Private partnership has emerged as one of the important strategies for architectural correction in health sector in country. Broadly two types of partnership have been reported- one relates to arrangement with NGOs/Trust, and another with the large corporate groups. In both, the main form of involvement has been health service delivery (including outsourcing of PHCs and UPHCs in Rajasthan, Andhra Pradesh and Telangana), management of MMU, ambulance services (104/108/102 services), diagnostic services, dialysis services, providing the diet, housekeeping and security services in different facilities at district and sub-district level.

Key Findings

1. Healthcare Infrastructure and Adequacy of Facilities

Compared to previous Common Review Missions, the States have reported improvement in adequacy of health infrastructure. Further, the number of health facilities running out of rented buildings have reduced markedly. However, shortages in number of health centres is reported from Bihar (48% shortage in SHCs and 42% shortage in APHCs) and Nagaland (13% shortage in SHCs). Time to care approach is yet to be institutionalized in most hilly States largely due to poor road connectivity and challenges related to inclement weather conditions in such remote areas. In most States the responsibility of healthcare infrastructure development is with PWD or similar departments (e.g. Rural development). However, the progress of infrastructure work appears to be better where the administrative control is within the health department (e.g. Maharashtra) or where the PWD has a dedicated medical wing (e.g. Tamil Nadu). Preferred framework for administrative control in medical infrastructure development could be an area for further exploration. A related challenge is the completion rate of health infrastructure and only Tamil Nadu (80%) and Madhya Pradesh (83%) report a good completion rate of health infrastructure. States with relatively poor completion rate of infrastructure include Bihar (29%) and Jammu& Kashmir (36 % DH, 50 % CHC, 35 % PHCs, 35 % SCs are still under construction).

2. Utilization of Facility Based Services and Continuity of Care

All CRM States report improved utilization of services as compared to previous years. The institutional delivery (in public institutions) ranges from 27% (Kerala) to 80% (Tripura). OPD per thousand population ranges from 505 (Nagaland) to 4589 (Chandigarh), whereas IPD per thousand ranges from 16 (Jharkhand) to 167 (Chandigarh). However, challenges of underutilization of services remain in North Eastern States (e.g. Arunachal Pradesh and Nagaland). Gujarat has again reported a preference for private sector as compared to public hospitals. Some other States that report relatively lesser utilization of public hospitals for

institutional delivery services include Kerala (27%), Andhra Pradesh (33%), Uttar Pradesh (41%), Jharkhand (45%, Nagaland (45%), Arunachal Pradesh (49%) and Maharashtra (50%). While RCH related services are now fairly available in different level of public dispensaries/hospitals; there are challenges pertaining to provision of NCD services. Barring Tamil Nadu, none of the States have institutionalized provision of NCD clinics (particularly at the level of CHCs/PHCs). Provision of services related to mental health, emergency care and geriatric care are also limited at the level of district hospitals in most of the States. Kerala continues to lead in provision of home based palliative care.

3. Health Systems Strengthening Through Public and Private Sector

3.1. Drugs and Diagnostic Services

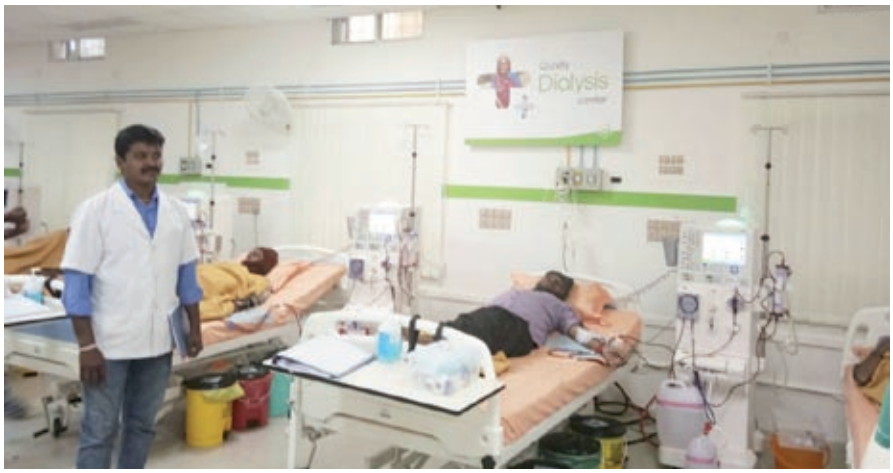
3.1.1. Drugs

All CRM States, except Arunachal Pradesh, report having a notified Free Drugs Policy. Arunachal Pradesh is yet to notify Free Drugs Initiative and beneficiaries in the State were incurring Out of Pocket Expenditure (OOPE) on medicines. OOPE were also observed to be incurred in States like Bihar and Nagaland due to unsatisfactory implementation of the scheme as well as ineffective supply chain management. In some States (e.g. Himachal Pradesh) OOPE on drugs is on account of limited number of free drugs in the Essential Drug List. Prescription audits are yet to be institutionalized and STGs are not practised while prescriptions in almost all States. Procurement of drugs by brand name (rather by generic name) was observed in Nagaland, which is pushing the costs and limiting States ability to procure enough drugs to meet its demand. Supply of drugs was observed to be delinked with the indents generated from health facilities in the States of Nagaland and Arunachal Pradesh, leading to inappropriate supply and large stock of expired drugs at health facilities. Digitalizing of indenting through electronic platforms such as e-aushadhi/Nirantar have been adopted in all CRM States barring Arunachal Pradesh, Nagaland and Chandigarh. However, limited capacities of personnel at drug warehouses and procurement bottlenecks indicates instances of stock-outs persist across multiple States (e.g. Arunachal Pradesh, Bihar, Chandigarh, Himachal Pradesh, Kerala, Nagaland, Tripura). Availability of centrally supplied drugs and commodities were found to be adequate across all States. CRM reports that NABL accredited labs are ensuring the quality of drugs across all States except in Arunachal Pradesh and Jharkhand.

3.1.2. *Diagnostics*

The implementation of Free Diagnostics Services Initiative needs to be expedited in States/UTs. At present, varying range of free diagnostic tests are being provided in all CRM States. Andhra Pradesh, Gujarat and Madhya Pradesh have implemented pathology services under the Free Diagnostic Services program. PPP arrangements for provision of diagnostic services were also observed in Delhi, Himachal Pradesh and Jharkhand. However, the comparison of these PPP arrangements vis a vis the National Free Diagnostic Service initiative-

particularly on the aspects of cost efficiencies, turnaround time and quality of care- are yet to be studied. Further, a considerable OOPE on diagnostics has been reported from Arunachal Pradesh, Jammu and Kashmir and Nagaland. Isolated instances of OOPE on diagnostic tests were observed from Chandigarh and Tripura too. Issues related to lack of supplies/reagents (in Bihar) and costly diagnostic equipment lying unused (in Arunachal Pradesh and Nagaland) were also observed.



3.2. Dialysis Services and District Hospital Strengthening

3.2.1. *Dialysis*

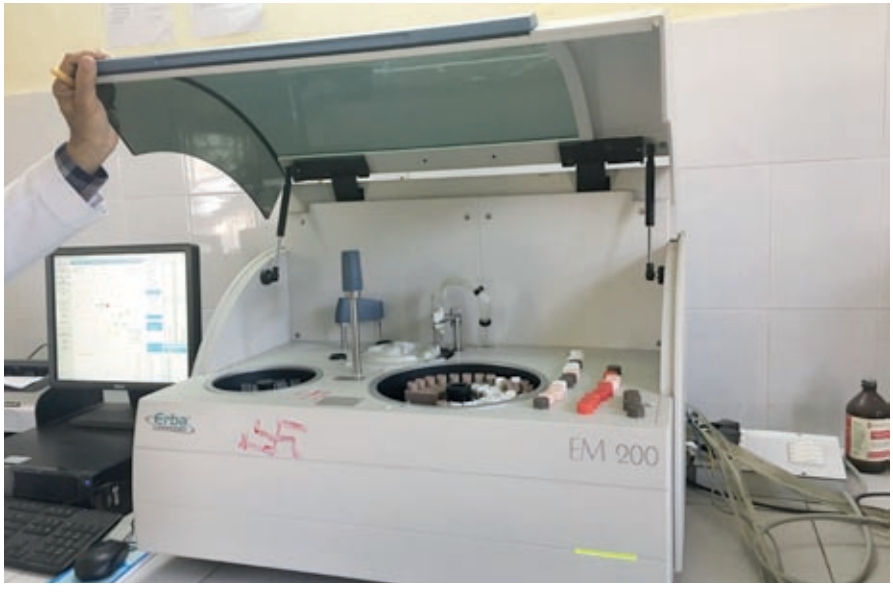
Arunachal Pradesh, Jammu and Kashmir, Nagalandand Jharkhand are yet to operationalize dialysis services at district level through PPP mode. Some States where better progress was observed include Andhra Pradesh (11 centres), Bihar (17 centres), Maharashtra (30 centres), Himachal Pradesh (3 centres functional and tender floated for 6 more) and Tamil Nadu. However, none of the States report dialysis services being scaled to all districts. BPL populations have been exempted from costs for availing dialysis services across all States. However, costs related to central line insertion was observed in Madhya Pradesh.

3.2.2. District Hospital Strengthening

Currently most of the District Hospitals report provision of specialist's services. However, the range of services (including specialists' services) are not up-to IPHS standards in many instances and this is acting as a hindrance for developing district hospitals as training centers. Amongst the States visited under 10th CRM the States of Jammu& Kashmir, Tamil Nadu, Himachal Pradesh, Tripura and Madhya Pradesh have initiated the process for Strengthening of District Hospitals to develop them as training centers. However, many other States such as Andhra Pradesh, Arunachal Pradesh, Delhi, Gujarat, Jharkhand, Kerala, Maharashtra, and Uttar Pradesh have yet to report any progress in this regard. Overall, the initiative needs further push to be scaled up.

3.3. Blood Services

Inadequate availability of blood has been reported as a concern in the States of Nagaland, Gujarat, Arunachal Pradesh, Uttar Pradesh, Jammu and Kashmir and Bihar. These States also report limited functioning of the Blood Storage Units either due to lack of trained human resources or non-linkage with a mother Blood Bank. For



instance, Nagaland has only 3 blood banks functional (out of 8 in the State) and Arunachal Pradesh too has 3 functional blood banks (out of 9 in the State). Jammu and Kashmir and Bihar have reported challenges related to renewal of licenses of the blood banks. States/UTs reporting better functioning blood services are Tamil Nadu, Maharashtra, Andhra Pradesh, Chandigarh and Maharashtra. Where adequate blood is available, it was observed to be provided free of cost to pregnant women, while for other patients a charge ranging from Rs. 500 to Rs. 750 was levied (except in Tamil Nadu). Replacement stays the major source of procuring blood in most States. Bulk of blood transfusions continue to happen at the level of district hospitals.

3.4. AYUSH

Provisioningof AYUSH services have improved as compared to previous CRMs. However, it was observed that in Andhra Pradesh, Arunachal Pradesh, Gujarat and Madhya Pradesh the provisioning of AYUSH service is inadequate at sub-district level. Further, it was observed (across all CRM States) that protocols for internal referral between the AYUSH and other departments are non-existent. Kerala (30-40%), Bihar (16%) and Uttar Pradesh (12%) have reported relatively higher percentage of AYUSH utilization. However, trainings for AYUSH medical officers is limited to SBA and screening for defects under RBSK program. Erratic availability of AYUSH medicines and supplies continues to be a challenge and needs further attention. For instance, the States of Gujarat, Himachal Pradesh, Maharashtra, Kerala, Nagaland and Uttar Pradesh have reported limited supply of AYUSH medicines and stock-outs at co-located facility.

3.5. Ambulance, Referral Services and Mobile Medical Units

3.5.1. Ambulance and Referral Services

All States covered under the 10th CRM except Jharkhand, Kerala, Tripura and Nagaland now have call centers linked ambulance services. The analysis of the data from the State reports demonstrate that there is a significant increase in the number of institutional deliveries in public sector institutions in districts after implementation of 104/102 referral services. However, ensuring a rational deployment of ambulances remains a challenge in hilly States like Arunachal Pradesh and Jammu and Kashmir. Further, the complement of equipment and human resources in Advanced Life Support ambulances is inadequate in many instances. With regards to training of Emergency Medical Technicians, most of the States -except Tamil Nadu and Maharashtra- have reported that the training of EMTs is not up to the desired level in terms of duration and knowledge retention. All the States have reported presence of GPS in ambulances except Arunachal Pradesh and Jammu & Kashmir. In absence of this facility, it is difficult for the both of the States to monitor the performance of the ambulances. Data provided by State reports reveals that on an average 133-212 km are covered by per ambulance per day. However, there is a wide range in average number of trips made per ambulance per day. On an average one ambulance undertakes 3-8 trips per day.

3.5.2. Mobile Medical Units

All States, except Delhi, reported to utilize MMUs for outreach services. However, the degree

of utilization varies from state to state because of poor planning, lack of human resources and weak IEC activities. Andhra Pradesh, Gujarat, Jharkhand, Maharashtra, Kerala and Tamil Nadu have reported better utilization of MMUs to provide health care services to tribal and marginalized population. On an average, these States have reported 75 to 80 OPD per trip per vehicle. However, relatively limited utilization (due to lack of planning, human resources, finance and awareness among community) was observed in States of Arunachal Pradesh, Bihar, Jammu & Kashmir, Madhya Pradesh, Nagaland and Uttar Pradesh. To cater to Mahadalit populations the State of Bihar has roped in funds from MPLAD (Member of Parliament Local Area Development Fund) scheme. Himachal Pradesh has recently initiated the process to operationalize MMUs through PPP arrangements in 10 districts.

3.6. Bio Medical Equipment

Maintaining the functionality of equipment with minimal "down-time" has been a challenge especially in remote locations of most of the States. Almost all States visited in 10th CRM reported intention to implement a Comprehensive equipment maintenance program as per Government of India Guideline. Andhra Pradesh, Kerala and Maharashtra have implemented the Biomedical Equipment Maintenance Program. In Tripura, Nagaland and Arunachal Pradesh the tendering process has been

completed, whereas Uttar Pradesh and Himachal Pradesh have released the RFP. Madhya Pradesh, Delhi and Tamil Nadu (where TNMSC is managing the maintenance) have completed the mapping of equipment. Gujarat, Jammu and Kashmir and Jharkhand are yet to implement the program. Further, the CRM has observed challenges in terms of a) functional equipment lying unutilized (Arunachal Pradesh), and b) old non-functional equipment occupying space in warehouses (Nagaland) and in health facilities (Jharkhand, Tripura).

3.7. Other Public Private Partnership/Outsourcing Arrangements

Almost all the States - except Kerala - have reported to have entered into Public Private Partnership to strengthen delivery of Health Services. The Public Private Partnership arrangements include management of, a) ambulance services (in Arunachal Pradesh, Bihar, Himachal Pradesh, Jharkhand, Madhya Pradesh, Maharashtra and Tamil Nadu), b) diagnostic services (Arunachal Pradesh, Andhra Pradesh, Delhi, Himachal Pradesh, Jharkhand, Tripura and Uttar Pradesh), c) dialysis services (Andhra Pradesh, Himachal Pradesh and Maharashtra), d) MMU services (Jharkhand, Maharashtra, Bihar and Tamil Nadu), e) health centers (Arunachal Pradesh, Andhra Pradesh, Gujarat, Nagaland and Tamil Nadu [Dental clinic]). The out-reach services are being organized with the help of civil society partners in the state of Maharashtra and Tamil Nadu. There is AMC for Biomedical waste management, managing the diet, housekeeping and security services at district and below district level in almost all States. Sound contract management, basic cost and quality monitoring are still far from achieved, though in principles they have been recognized as critical elements for a long time.

3.8. IEC/BCC

While all States visited under 10th CRM reported undertaking IEC and BCC activities at state, district and below district level; the States of Andhra Pradesh, Maharashtra, Tamil Nadu, Kerala, Tripura, and Himachal Pradesh were observed to be more efficient in using this medium in improving the health service delivery to marginalized and tribal population and creating awareness among community about health services and health behaviors. These States have strategized IEC activities as per local needs and ensured that IEC material is available in local languages. Arunachal Pradesh, Nagaland and Uttar Pradesh were observed to be lagging

behind due to lack of IEC/BCC strategy, human resources, financial support and capacity building of staff. More IEC/BCC activities is required for programs like NUHM, RBSK, RKSK, and health of tribal and marginalized populations.

3.9. Innovations and Best Practices

Almost all the States visited under 10th CRM, have reported various best practices and innovative approaches to improve the quality of health care, reductions in costs and access to public health services. The range of observed best practices and innovations is wide and includes, a) e-initiatives, b) initiatives for community health volunteers (ASHAs/Saihhyas), c) initiatives related to community empowerment, d) RMNCH+A program initiatives, e) measures to improve access to drugs, f) improved access health care, including primary care, AYUSH services, care for gender based violence and NCDs, f) financial protection and g) quality of care.

In current CRM States only Tamil Nadu have operationalized the innovation "Strengthening Tertiary Care for Cancer Treatment" which was presented by Punjab in the 2nd National Summit on Good and replicable practices & innovations. None of the other CRM States have shown substantial progress on commitments made by them in 2nd and 3rd National Summits. Further, about 118 product innovations have been uploaded for review on the National Health Innovations Portal. Following are innovations and best practices observed by various CRM teams:

- **E-initiatives:** DAWA app (Delhi); Matritva app, EpiMetrics app and an Immunization app (Maharashtra); Chetna app (Madhya Pradesh) and ANMOL and E-Smart in Andhra Pradesh.

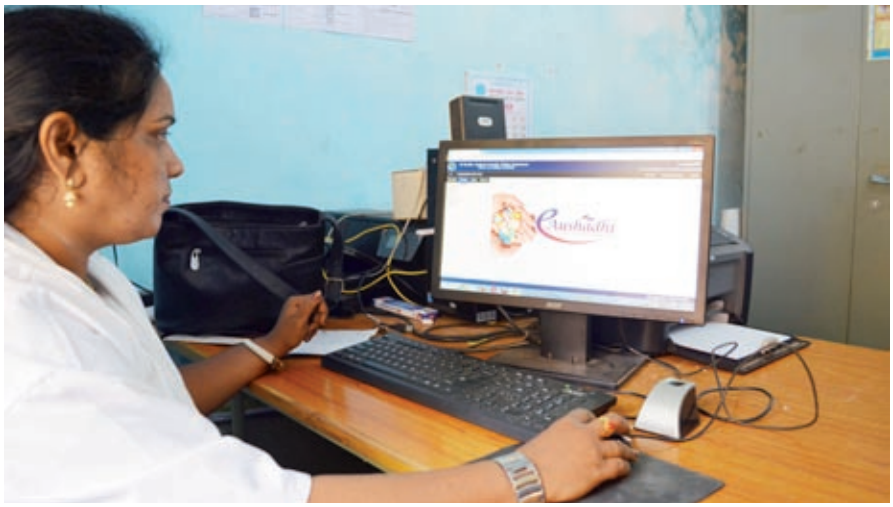
- Initiatives involving **Community Health Volunteers:** Participatory Learning and Action (PLA) at block/districts level, Social Security scheme for Sahiyas and Sahiya Help Desks in Jharkhand; nomination of District and Block ASHA Coordinators from permanent cadre employees of the health department in Jammu and Kashmir.

- Initiatives under the umbrella of **RCH program**: Amma Baby Care Kits, Breastfeeding rooms in Public Places, Scheme of Sanitary Napkins, Breast Milk Banks, Amma Whole Body checkup and Amma women special checkup scheme and Amma Arokiya Thittam Schemes of Tamil Nadu; Birth Waiting rooms and "Suraksha-Community based advanced distribution of Misoprostol" in Himachal Pradesh; New Born Screening for Neurological Disorders in Kerala; Yukti Yojna in Bihar; Mahila Master Health Checkups for common NCD/cancers and *"Mana Bhavitha"* and *"Anna Amrutha Hastam"* special health camps for screening thyroid and other obstetric conditions at SHC level in Andhra Pradesh.

- Initiatives taken to increase **Access to drugs:** Jan Aushadi (Kerala); Universal Access to TB Care and Single window TB-HIV treatment services in Maharashtra; and "Sanjivini" in Bihar.

- Initiatives for **AYUSH System:** AYUSH Gardens in Maharashtra where Health related herbs, plants and creepers are planted and used.

- **Financial protection initiatives:** Chief Minister's Comprehensive Health Insurance Scheme and Dr. Muthulakshmi Reddy Maternity Benefit Scheme (Tamil Nadu); Arunachal Pradesh Chief Minister's Universal Health Insurance Scheme (Arunachal Pradesh); social security scheme for Sahiyas (Jharkhand). Initiatives to provide quality Primary health care: Aam Admi Muhalla Clinic (AAMC) in Delhi; Migrant Workers



screening camps at the borders (Kerala); Private Pay clinics at Itanagar (Arunachal Pradesh).

- **Non Communicable Diseases** initiatives: SHAPE (Systematic Health Assessment for Police Personnel) and LEAP (Lifestyle Education and Awareness Program) for school children in Kerala; and Strengthening Tertiary Care for Cancer Treatment in Tamil Nadu. Initiatives taken specifically for improvement of **Mental Health** areestablishing Mental Health Screening & Counselling Room "Maan-Kaksh" in Madhya Pradesh, De-addiction Centers in Bihar, Care and rehabilitation for mentally ill in peripheral institutions in Kerala.

- **Gender Based Violence Management Initiatives:** "Bhoomika" centers at district level in Kerala.

- Good infection control Practices and CSSD at DH Mon in Nagaland

- Health infrastructure: 'Health Goes Green' in Tripura.

- Access to blood: Blood on call in Nasik public hospitals (Maharashtra)

Recommendations

1. States may explore the possibility of bringing the infrastructure work related to hospitals/other medical institutions under the administrative control of health department. This could aid in expediting the completion of sanctioned infrastructure.

2. NCD services need to be strengthened under the NPCDCS and other non-communicable disease programs. States should strengthen human resources (at the level of districts) under these programs. Further, States should be reoriented about the various guidelines for various NCD programs specially related to setting up of NCD clinics.

3. Promoting procurement of generic drugs through robust agencies/societies dedicated for this purpose and increasing the number of drugs under Essential Drug List(s) are key steps that States need to undertake for reducing OOPE on drugs and improving access to drugs along with institutionalized prescription audit mechanisms.. Formulation of an Essential Diagnostics List could be considered too.

4. District Hospital Strengthening: States should prioritise district hospitals that have the four basic specialties of Gynaecology, General Surgery, Anaesthesia and Peadiatritics and plan/ propose for developing these as training centers.

5. Blood: There is a need for supporting States in renewal of licenses and in roll out of online platforms for management of blood services. Greater coordination with private blood banks is also required.

6. AYUSH: Previous CRM recommended linking of AYUSH procurement with general procurement of other drugs and supplies. 10th CRM recommends the same with regards to procurement of AYUSH drugs and supplies. Integration of AYUSH human resources in implementation of National Health Programs needs improvement.

7. Ambulances: Focus needs to shift towards ensuring quality emergency care in Advanced Life Support ambulances and building the capacities of emergency medical technicians. In States where the call center based ambulances are yet to be streamlined, there is a need to expedite the function a ling of call centre based approach or explore alternatives to ensure assured, timely and quality referral services MMU: States must ensure that MMU routes are planned to cover areas where service delivery is unreachable either through health centers or outreach sessions. This must stay the cornerstone of MMU planning. In hilly States, particularly in North Eastern region, where one MMU per district is often inadequate States may seek support for additional MMUs under NHM.

8. Biomedical Equipment: In States where the program has been already rolled out the focus now should be on monitoring the quality of services provided by various private partners and ensuring that adequate grievance redressal mechanisms are institutionalized. States where tendering process has completed/in-process, must ensure that the inventory process is initiated and completed at the earliest.

9. PPP arrangements must be viewed with the lens of transparency and accountability of all involved stakeholders. States may consider having a dedicated cell within the ambit of State Program Management Units to guide as well as review the PPP mechanisms.

10. IEC and BCC: State needs to integrate IEC Cell created by NHM and Media Bureau or IEC/BCC Bureau managed by Directorate Health and Family Welfare. Further, IEC in form of wall painting should be rationalized and other modes of IEC/BCC particularly local cultural groups involvement for influencing tribal and marginalized behavior should be strategized or plan.

State Findings

Arunachal Pradesh

- Most of the infrastructure works given under NHM has been completed by the state. State needs to have differential budget for hard to reach areas.
- Although all the facilities from PHC above are providing OPD and IPD services, they were mostly being utilized sub-optimally.
- National Free Drug Initiative has not been notified in the state. There was huge Out of Pocket Expenditure on drugs in the State (up to Rs.5000 per patient even for 'delivery' cases). Facility wise EDL is not updated and was not found in any of the facilities visited except the one operated by NGOs. There is no centralized procurement agency. Basic drugs viz. ORS, Zn, WIFS, IFA, Injection Mag Sulph, calcium, rabies vaccines etc. were not available in the districts visited (except in few facilities e.g. PHC Siley). There is no drug warehouse in the state and office buildings are being used to store drugs.
- National Free Diagnostics Initiative has not been implemented yet in the state. Facilities visited were conducting basic tests. There was huge OOPE incurred (both JSSK and Non JSSK) on diagnostics.
- State has finalized the RFP for Prime Minister National Dialysis Programme.
- There are 9 Blood Banks in the state, out of which 3 are functional. The infrastructure for 5 blood banks and 11 BSUs has also been completed.
- In the State there are 88 collocated AYSUH facilities and 122 Medical officers in the State. AYUSH doctors in the state were available at DH, CHC, and PHC level. There were adequate AYUSH drugs available in both East and Upper Siang district.
- There are 94 ambulances (102), supported by NHM and have a call center at Itanagar. However, in both the districts, the transport services are not

available for pregnant women. GPS and equipment is not fitted in ambulances and there was no linkage to call center.

- MMU is operational in 16 out of 20 districts in the state. It mainly serves the unreached population of the state. However, the functionality of MMUs are poor and on and average OPD rate of each MMU is 30 only.

- State has not completed the mapping of Biomedical equipment. Unused CT scan, Endoscopy machines, X-rays and ECGs were seen dumped in CHC Ruskin by CRM Team.

- Karuna Trust, a national NGO and Future Generation, a local NGO have been given responsibility of managing some Primary Health Centers and Sub Centers. The NGO is provided Rs.2.66 lakhs per month for providing support to PHC. The '102' ambulances are being run by GVK-EMRI.

Andhra Pradesh

- Adequate infrastructure of all health facilities i.e. DH, AH, CHC's, PHC's and sub centres and all are accessible to the people. Except sub centres, all other health facilities are functioning in government building. The maintenance of the buildings is largely satisfactory.

- Increased footfalls in all levels of facilities. Healthcare services are effectively rendered as indicated by outpatient and inpatient data.

- Free Drug Scheme is being rolled out through the e-aushadi initiative - all patients visiting government health facilities are provided with their entitlement of drugs. A supply chain management software developed by C-DAC is introduced for end to end online inventory management solutions.

- National Free Diagnostics Program has been launched in the state and patients are able to access and avail services under this initiative. No OOPE reported by the beneficiaries.

- There is a good linkage between Blood Banks and Blood Storage Units, with a total of 134 Blood Banks and adequate BSUs. The State has also recently launched the Blood Bank Application, which is expected to further increase the voluntary donations at higher centers such as District Hospitals.

- AYUSH services are being provided with adequate medicines in the visited district hospitals facilities and patients availing these services expressed their satisfaction. But AYUSH services in the state are not satisfactory at sub district level and there are many vacant posts. The contractual AYUSH staffs are not getting the salary for the last eight months.

- There are 227 Mobile Medical Units providing fixed day Health care services to the community.

- State has provision for AMC for major equipment. The biomedical equipment Maintenance is being carried out on Public Private Partnership mode and 53,608 available equipment(s) have been tagged.

- The state has taken up a Public Private Partnership (PPP) initiative for many services. Among them most important are setting up one Dialysis Centre (under National Dialysis Service Programme) in each of the 13 districts and biomedical equipment maintenance. Currently 11 such centres are operational. However, state does not have any mechanism to monitor the services under public private partnership mode.

Bihar

- There is a 41% gap in existing functional HSCs and 51% gap in APHCs against sanctioned numbers in the state. There is a huge gap in sanctioned health infrastructure against IPHS norms with 12 medical colleges against 21 sanctioned, 126 FRUs against 208, 533 CHCs against 865, 2787 PHCs (APHC) against 3460 and 16623 in HSC against 20820.

- Infrastructure completion rate is around 29%. There is adequate

supply of running water and electricity with power back-up in most of the facilities.

- In the State, most of the patients are coming for OPD, deliveries and emergency care. C-section rate is below 2% and utilization of public health institutions in general was found to be good only at District Hospital.

- State has implemented free Drug Policy. Bihar Medical Services and Infrastructure Corporation Limited (BMSICL) is central drug procurement agency. Three NABL accredited labs have been empanelled for quality testing of drugs. All the primary care hospitals in the district are not connected online for submitting online indent. Patient registration and medicine dispensing software is good initiative but actual use of software for planning is not happening. Drug supply system is inefficient at district level. Supply depends on availability of drugs in district ware house rather than demand base.

- Periodical Prescription Audits are not being conducted. State is in the process of developing a comprehensive Standard treatment guideline. EDL list is displayed at DH, CHC and SDH. Doctors prescribe branded medicine rather than generic prescription and as these medicines are not available in Pharmacy, patients have to go private medical stores to buy medicines which lead to huge out of Pocket expenditure.

- Free Diagnostic Services are being provided in the state since 2009 in all public health facilities and the facilities of advanced pathological and Radiological tests (except CT Scan and MRI) are being provided free to the patients at Medical Colleges & Hospitals. The reagents are being supplied to districts by the BMSICL. However, shortage of reagents is being observed at all levels except District hospital.

- State has already initiated the Dialysis Services at 17 places and making arrangements to start the services at 7 more places.

- Although state has sufficient number of Blood Bank but there is a shortage of Blood Storage Units. Blood banks visited in the facility are having necessary IT logistics and are well connected with internet. Delay in receiving approval from State Drug Controller, Procurement of Equipment and Instruments, Lack of Human Resources (HR) as per norms, and lack of awareness amongst community for Blood Donation is an area of concern in the State.

- In the State there are total 69 Ayurvedic Dispensaries, 30 Unani Dispensaries, 28 Homeopathic Dispensaries (in rural areas), 26 Joint Dispensaries (Ayurvedic, Unani & Homeopathic) in 26 out of 38 districts. Further, 1348 AYUSH co-located facilities are available under NHM and 1060 AYUSH doctors are supported through NHM. However, in the visited facilities AYUSH MOs are not trained for National Programmes like SBA. Availability of AYUSH medicine is an issue in the state.

- In the State, 744 BLS ambulances are run by DHS, 10 (5 ALS + 5BLS) ambulances being run by Ziqitza Health Care Ltd. and 94 (44 ALS + 50 Mortuary Vans) are being run by Sammaan Foundation. Along with this, MPs, MLAs, philanthropic organization-NAHI and Disaster management departments have also provided ambulances to the state. There are three call centres operational -102, 108 and 1099. The average running of ALS is 4000 to 6000 kilometres per month. State has fixed a service charge, with some exemption for critical patients. There is a provision of service charge for hiring of ALS ambulance services and mortuary van.

- The state has provision of outreach services through Mobile Medical Units. However, it is limited only in two districts. There are seven MMUs (National Mobile Medical Units) and 73 MMVs (National Mobile Medical Vans) supported by Government of India and 6 MMUs are also provided through MPLAD fund for marginalized and Mahadalit section of the community.

- State has identified eight district level Hospitals to be developed as model district hospital in the state.

- The state is in process of outsourcing the Maintenance of Bio Medical Equipment. The mapping has been completed at all facilities up to Additional Primary Health Centres level across the state.

Chandigarh

- The facilities were adequately providing services including RMNCH+A. The referred cases were treated and sent back to the referring facility for follow up but there was no formal systematic mechanism of referral or complete referral.

- Cleanliness and patient amenities were satisfactory in all the facilities. Most of the facilities were spacious but considering the growing patient load at DH and CHCs, space was inadequate in some units.

- UT has not adopted E-aushadhi system as yet and there was evidence of shortage of some drugs.

- Routine diagnostic facilities are available for pregnant women and other general tests, except ultrasound. Women were referred to DH but most of the women had test reports from the private service providers.

- Three dialysis machines were available at District Hospital and out of these only two were functional.

- Four Blood banks and storage units on round-the-clock basis are working in the UT providing blood to at least 4-5 patients per day per centre. Only 300-350 units of blood are stored and distributed in a month.

- Ayurveda, Homeopathy and Unani service providers were available across facilities up to UPHCs. AYUSH drugs were adequately available at all the facilities visited and average OPD load ranged from 20-40 cases a day. There was no standard internal referral system between the AYUSH and other departments and internal referral was found minimal. Most of the AYUSH clinics were integrated within the same building and were not co-located. Overall data showed that over the years since 2011-12, OPD footfall has decreased continuously for all the three systems.

- UT has AMC with the manufacturers and suppliers of respective equipment's and therefore there are more than one vendors to manage these equipment's' maintenance. The UT has not yet implemented the guidelines of National biomedical equipment maintenance programme.

- The UT has taken up a Public-Private partnership initiative for lab services.

Delhi

- As per the State HMIS data for past three years, there has been a consistent increase in the utilization of the Public health facilities. However, the magnitude of increase has decreased from 2013-14 to 2014-15.

- State is planning to operationalize around a 1000 Aam Aadmi Mohalla Clinics (AAMC) and upgrade 260 dispensaries to polyclinics as second tier facilities which would offer specialist consultations.

- The State has adequate number of health facilities as per the population norms. However, the increasing number of OPD and IPD loads and overcrowding of existing facilities due to influx of cases from the NCR region necessitates the creation of more health facilities to distribute the caseloads uniformly.

- The UT of Delhi has initiated mobile dental health clinics for preventing and curative services. These mobile clinics conduct oral health education sessions in the communities and schools.

- The UT outsources the lab services for diagnostic test.

- There is a Free Drug Policy that was notified in 1994. EDL has up to 1417 drugs. UT has provided the flexibility

to the facilities to update and include more drugs depending on the facility's caseload and requirement.

- Central Procurement Agency is responsible for all procurements including medicines, consumables and equipment and fixed rate contract for essential drugs. Depending upon the indents received from the hospitals, the CPA places order with the suppliers for hospitals that receive drugs directly from the supplier. The supplier has to provide a quality check report along with every batch of drugs supplied.

- 8 NABL accredited labs check quality of drug supply after they are supplied to the facilities and the report of the quality check is sent to the facilities.

- Online Drug Supply management software Nirantar has been initiated, in which indents at hospital are made and orders are placed directly with the supplier from the CPA listed suppliers. The indenting at lower levels, i.e. dispensaries, polyclinics and UPHCs are made manually.

- DAWA App has been launched for beneficiaries to report any non-availability of drugs in government facilities. However, the same has not been publicized and none of the patients were aware of any such app. Most of the patients interviewed reported no expenditure on drugs.

- All public health facilities are providing diagnostic tests available at zero user fees. There were no reported expenditures incurred on diagnostic tests within facilities as reported by beneficiaries.

- The UT is utilizing Public Private Partnership for diagnostic tests by using its AAMC clinics for sample collection and outsourcing the test reports to the private labs, which provide test reports to the AAMC where patient collects it from.

- There are total 205 ambulances including 100 BLS ambulances procured under NHM. The State has recently bought the fleet of Ambulances under the Centralised Accident & Trauma Services (CATS). The ambulance has a trained EMT. The New BLS Ambulances are well equipped to handle emergencies and have US/FDA certified AED/Monitors, Ventilators and stretchers.

- The mapping of biomedical equipment has been done and updated on portal. Training of staff has been done as per new guideline.

- Operational since April 2016 in PPP mode in Hegdewar. On an average there is dialysis of 30 patients per day; operates throughout the day in 3 shifts; patients in BPL are provided free services and other patients have to pay a fee for service which varies per procedure. Fees are not too high for the services rendered.

Gujarat

- There is extensive presence of private sector in the state. Overall utilization of private sector is higher than country average, especially in urban area. There is overall satisfaction of the services.

- Procurement is at CMS level through GMSCL. E-Aushadhi is not being implemented fully. IEC materials are few regarding free drugs and diagnostics though it is freely available and OOPE on drugs was observed to be low in inpatient services. However, patients have reported spending money on drugs while availing outpatient services.

- None of the facilities had the latest EDL displayed as notified by the State Government. Staff was unaware of the facility wise EDL.

- Free diagnostics under the Mukhya Mantri Nidan Yojana is being followed. However, some of the tests are not available at many of the facilities.

- There is one blood bank in both the district. In Navsari it is run by the Indian Red Cross Society for the whole district. The licence for the blood bank in Navsari has expired, the organization has applied but it has not been renewed and no communication has been

made to the institute despite reminders. There is shortage of blood at the blood bank in DH, Gandhinagar and SDH, Mansa.

- It should be ensured that waste disposal at blood bank should be proper as per BMW 2016 guidelines.

- The 108 ambulance service is working satisfactorily. However, there is scope for increasing its utilization. Currently, the feedback from the state/PPP partner is not taken.

- The state has 30 GPS-enabled MMUs operational in 17 districts. There is micro plan with each of the vehicle visiting 18 villages in a week and 3 villages per day with on an average 75-80 OPD per day.

- The mapping of equipment has not been completed so far.

- State needs to follow the new guideline for Comprehensive Biomedical Equipment Maintenance.

- Public Private Partnership arrangement includes the Chiranjeevi and Bal Sakha Yojana. The NGOs are also involved for implementing the RMNCH+A services and other national programme i.e. NPCB, RNTCP, and RBSK activities. However, state does not evaluate the relevance of such initiatives in city like Gandhinagar where there is well functional medical college and specialists' available in public health care systems.

Himachal Pradesh

- State has adequate health infrastructure as per population norms (Hilly Area) On an average every health sub-center covers 3180 population, PHC covers 12715 populations and CHC covers 83370 population in the State. 30 percent completion of sanctioned civil works from 2011-12 to till date.

- Utilization pattern of IPD and OPD is reasonable in the state however; it varies across levels of facilities and districts. It was observed, in the both the districts, the OPD and IPD footfalls are concentrated at regional hospitals and to some extent at block level CHCs.

- Three districts Hospital Nahan, Chamba and Hamirpur have been upgraded to Medical Colleges.

- The State has also collaborated with All India Institute of Medical Sciences, Delhi and 17 primary Stroke Centers and two comprehensive Stroke Centers IGMC & RPGMC for Tele-stroke.

- Drug procurement systems in the State are through two different channels – the HP Civil Supplies Corporation and through local purchase. The rate contract for the drug purchase is decided at the State level.

- State has notified 56 essential drugs and 10 consumables free to all and displayed at all the facilities. Out of pocket expenditure on medicine has been noted from patients interacted by the both teams as they are not provided with medicines at the facility. State EDL has been approved with 378 drugs. Quality assurance of the Drugs is done by the Vendors supplying the Drugs through NABL accredited labs. Implementation of DVDMS (E-Aushadi) through C-DAC is in final stage. Most of the essential drugs like IFA, Zinc Tab. Inj. Magnesium sulphate etc. were found in facilities

- HP government entered into partnership with SRL labs to provide diagnostic services in 12 district hospitals and those with 100 bedded with high footfalls. However, this resulted in almost defunct of existing in-house lab that need to be review critically. Outsourced lab provides services free of cost for the BPL patients, JSSK, RBSK, and RSBY, Accident victims' beneficiaries.

- The State has adequate number of blood bank but there is a shortage of blood Storage Units (9 functional out of 37). State has initiated online blood bank management information system, which provides live availability of blood stock across all the district blood banks, blood group stock and also provides the list of blood donors registered with the

district blood banks. Difficulties in running the blood bank were cited due to lack of staff and other patient amenities. Blood collection was through small frequent camps, where 15-20 units of blood are collected.

- There are 1149 Ayurvedic Dispensaries, 3 Unani Dispensaries, 14 Homeopathic Dispensaries, 4 Amchi Clinics, 33 Ayurveda Hospitals and 1 Government Ayurvedic College. 56,57,780 OPD and 1,70,845 IPD were reported from these facilities in the year 2015-16.

- AYUSH doctors are not involved in implementation of the national health programmes. Contractual AYUSH MOs engaged under NHM at co-located facilities were observed as involved mainly in task shifting of allopathic doctors. Further, shortage of AYUSH drugs and non-availability of AYUSH pharmacists have been observed as bottlenecks in ensuring availability of AYUSH services in the co-located facilities. The directorate of AYUSH functions as a separate directorate in the State. However, there is no AYUSH para-medic available at co-located facilities in the state.

- The State has an additional 126 vehicles under 102 ambulance services, which are operational in the state. These ambulances are available only for drop back for delivered women, infant's family and planning camps beneficiaries. It also has Centralized Call center staffed with 9 personnel. The State has an established mechanism for the district level review and monitoring mechanism along with other stakeholders. There are 199 EMRI (108) ambulances for emergency response transport (National Ambulance Service) available in the state out which 187 functional and 12 kept under reserve. Of the total ambulance available, all of them were fitted with GPS system and are connected to a 24 seated centralized call center at Solan.

- MMUs have approved for 10 out of 12 districts in current financial year.

- The mapping of biomedical equipment in 602 out of 648 facilities has been completed. Bio-medical equipment's maintenance has not been outsourced. The concerned department and hospital management maintains the equipment's maintenance. The state is in process of floating the tender for Comprehensive Biomedical equipment maintenance.

- Dialysis service are available under PPP mode in District Hospitals in Solan, Mandi, and Dharamshala.

Jharkhand

- New and major constructions are taking snail pace and have not been handed over to the health department. Most of the visited facilities in the district are maintaining overall cleanliness, except the labour room (Garwha).

- Case load at OPDs at most of the facilities are fairly good number, but bed occupancy is mostly by MCH cases across all the facilities. No facilities are maintaining NCD register.

- All the facilities are providing free drugs to the patients and the mandate of generic prescription is in place, but prescription auditing is not in practice apart from DH.

- Standard treatment guidelines are not available at the facilities apart from DH. District drug warehouse, Godda has shortfall of drugs in spite of having a good storage space and HR.

- It is not clear how system of Quality Assurance for the supplies delivered at the health facilities is ensured. There is no mechanism in place to manage expired drugs, reagents and vaccine across the facilities in the district.

- Diagnostic services are free to the patients and are being outsourced to SRL at DH and all other facilities are doing diagnostic facilities by their own and are free of cost.

- Dialysis services are not available at the DH, Dialysis services have not being rolled out in the State.

- National ambulance services are not being rolled out in the State; State is in the process of taking up the services. Ambulance vehicles have been purchased and infrastructure procurement is under process.

- State has 94 MMUs operational across the state covers all 24 districts. There are three mobile medical units in each of the districts and managed under Public Private Partnership mode. The monitoring mechanism of the MMU services is in place. MMUs provide the services of OPD, drug dispensing and basic laboratory services only. The micro-plan and tour plan of MMUs are being maintained.

- The state has not initiated the Biomedical Maintenance Programme so far. Junk materials occupy many service areas affecting the health services.

- The State entered into partnership with different agencies for diagnostic services, managing MMU services, and maintaining cleaning and security services at District hospitals.

Jammu and Kashmir

- As per the population norms, overall there is adequate number of health facilities in Jammu and Kashmir. There has been considerable addition to the health infrastructure in the state under NRHM: 9 DH, 14 CHCs, 303 PHCs and 386 Sub centres being added. As per construction status of projects shared by State, 36 % DH, 50 % CHC, 35 % PHCs, 35 % SCs are still under construction. All the works pertaining to MCH wings and Maternity Hospital are still under construction.

- Utilization of services in Public Facilities has increased progressively over 3 years. FRU operationalization is however a challenge.

- State has notified Free Drug Policy. State has an Essential Drugs List (EDL) which includes: 23 drugs & consumables for sub-centres, 53 for PHCs and 68 for CHCs/District Hospitals.

- State has a centralized procurement agency (J&K Medical Supplies Corporation Ltd.) for procurement of Drugs and Machinery/Equipment. JKMCSL has empanelled 4 drug labs. Samples are being lifted from Regional Drug Ware Houses and sent for quality testing to empanel GLP certified and NABL accredited labs before distribution of the drugs.

- Process of procurement & supply chain management is being carried out through e-Aushadhi Software. No real time monitoring of drug inventory management system is being done. Prescription audit mechanism and grievance redressal mechanism is completely non-existent in the State. During exit interviews with beneficiaries at various level of facilities OOPE was observed.

- Free Diagnostic scheme not yet implemented in the State. Currently, Diagnostics services are provided at subsidized rates. The user charges for diagnostic services vary from facility to facility. There is no fixed norm across both the districts. Diagnostics services for haematology, CT scan and USG were available at all facilities visited.

- In district Ramban, Blood Bank is sanctioned in district hospital which was not functional at the time of visit due to an expired license. District hospital was not able to renew the license due to non-functional blood storage equipment in Blood Bank.

- Number of standalone AYUSH facilities in the state are 417 and co-located facilities are 398. AYUSH doctors are working under NHM in District hospital, CHC and PHC. They are posted under co-located facilities with allopathy system. The AYUSH MOs are receiving remuneration in time. AYUSH medicines are being procured centrally by the state and supplied to the district headquarters and health facilities.

- The State has a network of 1100 Ambulances operational including ambulances procured under NHM. 331 Ambulances were initially networked with

GPS fitting. However, later on the contract of vendor was discontinued in Kashmir Division. At present 200 ambulances are operational under 102 Ambulance service in Jammu Division. As per data shared by State, Average no. of trips per ambulance per day at state level is 1 and in Ramban it is 3. Average distance travelled per ambulance per day is 46.2 km at State level and in Ramban it is 42.3km. Ambulances are underutilized; log books are not being maintained, high down time, no registration numbers in some of vehicles, some ambulances travelling on an average 300 km/trip/month. On an average one ambulance is making less than one trip/day. Community was not able to call the ambulance directly. They contact their ASHA who further make calls to ambulance driver or other staff of the facility whomsoever available at that time.

- The state has 11 MMUs – 1 vehicle for each High Focus district. Total 77,039 OPD and 2,363 lab test had conducted in MMU camp for financial year 2015-16.

- The mapping of biomedical equipment is in process.

- The state of Jammu &Kashmir has identified 10 district hospitals with high case load for rolling out the National Dialysis Programme under Public Private Partnership mode. Pradhan Mantri National Dialysis Programme is being launched in the State.

Kerala

- A good healthcare infrastructure exists throughout the state with a network of health facilities reaching up to rural areas. Most facilities are easily accessible and having un-interrupted electricity and water supply. Most AYUSH dispensaries are in old rented building provided by the local self-Government. Strengthening the available infrastructure in terms of new construction/renovation, availability of drugs and supportive services such as lab facility and radio-diagnosis facility is the need of the hour.

- Hospitals are primarily being used for deliveries and NCD related disorders that could be actually handled at lower levels. A large number of PHCs and CHCs are only providing OPD services or dispending drugs for NCDs and are closed by 2 pm. At CHC/PHC level, RCH services, Family Planning services (IUCD insertion, abortion care) are not being provided and deliveries are not being conducted in spite of having adequate infrastructure.

- A very effective model of palliative care is found to be in place till the level of PHC. At every level regular monitoring mechanism are in place. All the staff from Doctors to supporting staff provides home care.

- The drug procurement system is transparent and provided by the KMSCL. The essential drug list comprises 585 drugs in and drugs are being supplied both on pull and push mechanism by KMSCL.

- Even after the additional medicine distribution scheme like KARUNYA, AROGYA Kiran etc. are made operational, there are periodic out of stock positions are reported from majority of the facilities.

- Almost 30-40% of population prefer traditional system of Medicine specially –Ayurveda and Homeopathy. The current infrastructure and workforce is inefficient to cater to the needs of the patients. The bed occupancy rate is more than 100% in the Ayurveda Hospitals. With a long treatment cycle, the numbers of patients that can be catered get restricted due to less number of beds. Integration of services was observed at facility level. However, there is no institutional coordination for referral mechanism between modern and AYUSH facilities.

- The state is yet to initiate free referral transport services under JSSK; with the beneficiaries being paid Rs 500 each as the transport allowance (stopped since July 2016). However, under MLA fund/MP fund/HMC fund most of the facilities in Kollam district are providing Ambulance services. However, ambulances do not have any ALS services.

- MMUs services are utilized to provide the health services in remote area with an approach of fixed day and fixed time. All essential medicines and drugs are available and dispensed.

Maharashtra

- Physical conditions of DH, SDH, PHCs, and CHCs were found to be good with proper cleanliness and green campus.

- The civil works for health department are dealt by Infrastructure Development Wing (IDW) housed in State SPMU office under the administrative control of Mission Director-National Health Mission. Having an exclusive civil works wing allows the NHM works to be completed earlier than those allotted to CPWD of the State.

- Utilization of public health institutions in general is found to be good. It was also found that AYUSH clinics are rendering satisfactory services in DH, SDH and PHCs.

- Essential drugs and vaccines are largely available in all the visited facilities and Free Drug Services scheme has been implemented. Availability of essential drugs is displayed at all facilities.

- Procurement of essential drugs is done centrally at the State Level through e-tendering process. IT enable drug management system i.e. "E-Aushadhi" is available. Quality testing of drugs is done at the State level through NABL accredited laboratories.

- At present, 30 units are identified where dialysis services are available.

- Nashik District has 14 licensed Blood Banks and 20 Blood Storage Units. All existing blood banks and BSUs are operational 24 X 7. In, Nagpur District, Women's hospital had a fully functional Blood Bank and storage unit; and in 2016, till Oct 2016 had collected around 3000 units of blood through donation camps. 20% of the units collected were given away through Blood on Call'.

- 1825 AYUSH facilities are co-located at various health care facilities and 2980 AYUSH medical officers are appointed under NHMRs 15. Special AYUSH wing was developed at DH Nashik in 2011-12. In Nagpur District, mainstreaming of AYUSH is seen within the main health delivery system. AYUSH Medical Officer is providing various clinical services and dealing with administrative matters at PHC level. AYUSH drugs are being provided from State Health Society. But it was informed that since last one year drugs for Ayurveda and Unani are not being supplied.

- 590 ambulances including 450 Basic Life Support ambulances (108) and 2754 patient transport service vehicles (102) are operational in Maharashtra under NHM. In Nashik district, there are total 46 ambulances out of which 11 are ALS and 35 are BLS. During Jan-Oct this year, 22,612 patients had been served.

- On an average 7-8 trips and average of 150 to 170 km are travelled by per ambulance per day. Average time taken by an ambulance to reach the scene is around 30 minutes. From community interaction, it was observed that ambulances are easily available even in difficult terrain. Some telephone connectivity issues were observed in tribal area.

- It was felt that due to availability of two numbers, i.e. 108 & 102 and both being rendered by separate service providers, there is confusion amongst the beneficiaries. It was also noted that there is far greater number of drop backs than pickups of pregnant mother/ill children under JSSK scheme.

- The utilization level of Mobile Medical Units in Maharashtra is high. The State caters the health services to population living in remotest area through the MMUs, floating ambulances and dispensaries. 40MMUs, 6 Special MMUs, 3 floating dispensaries are operational in Maharashtra.

- The mapping of all Biomedical equipment has been completed

and work order has also been issued for outsourcing of equipment maintenance services.

- The State also entered into partnership with NGO to implement "Community Action for Health and Decentralized Participatory Health Planning (DPHP)". The Community Action on Health process is implemented in 600 villages across 13 districts while DPHP in 360 villages of 14 districts.

- The outsourced services in State of Maharashtra are Ambulance (Bharat Vikas Group), MMU services (different NGOs and Organisations), 102 drop back services, Health Advice Call Centre -104 including grievances redressal and Blood on Call services, Medical camps, diet, laundry, housekeeping and security services at District Hospitals, Sub-Divisional Hospitals, Rural Hospitals and Primary Health Centres.

- Due to effective MMU services under PPP mode, the outreached services has increased and IEC/BCC interventions became operational.

Madhya Pradesh

- 83% completion of infrastructure at State and district level. Water and electricity connections were available in DH, CH, CHC and PHC. Majority of Sub-centres were well equipped and functional with all required logistic.

- Facilities are distributed as per geographical needs however its functionality and coverage by assured transport is an issue for time to care approach.

- Sardar Vallbhai Patel Aushadhi Yojana has ensured the availability of essential drugs. State has its own Essential drug list 2016-17 with 436 drugs approved under it. However, number of drugs are made available at various levels vary.

- Standard treatment guidelines were developed but they are yet to be disseminated. There is an IT enable inventory system present till CHC for management of drugs and logistics. However, indenting is done by own analysis, software should forecast depending upon consumption.

- Drug testing is done in 11 empanelled laboratories which are NABL accredited. Drugs are directly received from the manufacturer and quarantined till in house testing report comes. All drug ware houses and stores have IT enable inventory management system present – called E- Aushadhi.

- All the essential diagnostic services being provided at free of cost in all facilities. In interaction with the beneficiary at different centres there was no out of pocket expenses incurred on diagnosis at any facility at any level.

- Both districts have dialysis units. Utilization is better in Ratlam. The services are provided at free of cost to BPL patient whereas Rs. 800 charged to patient in APL category. AV fistula as well as Central line insertion is not performed at district hospital which costs about Rs. 18000 to the patient.

- State has not proposed any district under DH strengthening however DNB courses have been sanctioned at one district hospital JP Hospital Bhopal and bridge courses for nursing staff at Gwalior district hospital.

- The State has 135 licensed blood banks (Govt. blood banks 60, IRCS/Charitable 06, Pvt 69 & 71 BSC). It was found that the medical officer and technician were not aware about SoP as well as discard process for unused or waste blood unit at Ratlam. The blood collection was mostly done by replacement. The blood bank services are provided free for maternity cases and BPL families and processing charge of Rs. 600 is taken from others.

- The AYUSH doctors and other Staff are not under the administrative control of District CMHO.

- 8 Ambulances are functional and transporting the patients. However most of the critical

equipment's were non-functional. As per the available data and records, the average travel distance of each ambulance is 212 km per day and 4.6 cases per day.

- The operationalization of MMUs services in state varies from district to district due to lack of staff and poor IEC activities about MMU in community.

- The feedback received from the beneficiaries revealed that both during the call and arrival of ambulances the call centres asks too many questions which leads in long waiting time. More than 12 minutes they are wasted on various questions asked by the call agent.

- Although EMT was trained for 60 days needs hands on training but he was not aware about the use of basic drugs. None of the supervisors from outsourced agency verified the ambulance at designated site, 108 omni ambulance was verified at district level by supervisors of out sourced agency but false verification was done.

- The state has initiated the process of mapping of biomedical equipment recently. No AMC has been done for maintenance of equipment.

- The State of Madhya Pradesh has empanelled 11 agencies for quality testing. All empanelled agencies are NABL (National Accreditation Board for Testing and Calibration Laboratories) accredited. It includes the drug testing also. The state has outsourced the Ambulance services, technicians and in-house nurse for running the Dialysis unit. The poor quality of services and lack of supervision were observed by the CRM team.

Nagaland

- The state has adequate infrastructure in terms of number of health facilities as per population norms, except at the level of SHCs where there is shortfall of 13%.

- As most of the State has proposed only Specialist HR under DH strengthening during FY 2016-17 (based on the requirement as given by DHs). The recruitment is under process.

- Owing to poor development of civil infrastructure (particularly roads), inclement weather conditions, non-availability of assured public transport and out of pocket expenditure on drugs (including for JSSK beneficiaries) and diagnostics the general health seeking behaviour is tilted more towards home based care rather than institutional care. This has resulted in underutilization of health facilities at all levels. However, OPD utilization and number of major surgeries do show an upward trend.

- All the drugs and supplies are procured centrally in the State. For most of the health facilities the supplies are not linked to indents and consequently many instances of (unused) expired medicines, inappropriate drug supplies and stock outs (of IFA tablets, zinc tablets, Inj. MgSO4 etc.) were observed. No inventory management system was observed to be in place and there is 'push system' of drug distribution rather than a demand based 'pull system'.

- The State is procuring drugs by brands which is leading to high procurement cost. It is pertinent to note here that in absence of supply of drugs to the facilities, almost the entire untied fund available with the facilities is utilised for purchasing drugs and supplies from local market.

- The state has floated the RFP for free diagnostic services. Significant out of pocket expenditure (in the range of 500 to 2000) was observed to be incurred on the diagnostics.

- Principle approval has been accorded for free dialysis services to poor in 5 DHs of the State.Currently, thedialysis services are functional at the State hospital in Kohima.

- None of the districts had assured blood services available. As of now the blood is managed on the case to case basis and largely dependent on voluntary donations. Currently

the State has only 3 functional blood banks however; the State has so far not looked into the possibility of linking its blood banks or bringing the blood availability status on an online platform. Non availability of assured blood services is also one of the major factors behind non-availability of a FRU in both the 10th CRM districts.

- In the State there are 43 AYUSH MOs in position. However, they are mainly involved in RBSK and IDSP (as epidemiologists). Integration of AYUSH services is not significant in the State and supplies of AYUSH medicines were also observed to be erratic. As a result, AYUSH physicians are prescribing modern medicines and helping Medical officers in administrative work (thus defeating the prime objective of mainstreaming AUYSH services).

- Ambulance and referral services are not assured in the State. The awareness about ambulance services in the community is very low and it is a possible contributing factor for low utilization too.

- Despite high degree of OOPE incurred by pregnant mothers' ambulances were not promoted to be used for pick up and drop back services and most mothers' reported travelling by private vehicles. However, instances of inter-facility transfers of general patients were observed.

- MMU services are facing three major challenges in state: lack of medical officers, poor planning of MMUs camp and poor financial support. These factors combined together are leading to poor utilization of MMUs and poor geographical coverage. In some of the camps the districts attempt to mobilize the MO of PHCs nearest to the camp site; however this is not always feasible.

- The state has not initiated the Comprehensive Biomedical Maintenance Programme so far. No AMC/CMC or collaboration with any agencies was observed in state by CRM team. Several equipment like radiant warmer, suction machine, microscope, USG machine, X-ray, OT light, fully automated analyser were non-functional due to lack of AMC and maintenance mechanism.

- No significant Public Private Partnership mechanism was observed by CRM team in State of Nagaland.

Tamil Nadu

- State has adequate number of Public Health Institutions at all levels of care. As per RHS 2015, state does not have any shortfall of health Facilities. PWD has a dedicated medical wing for the purpose with a team of technical as well administrative staff in place from state regular cadre.

- Infrastructure completion rate is around 80% and the delay for pending works is only due to the land availability issue. The general up keep of the facilities is good. There is adequate supply of running water and electricity with power back-up in most of the facilities visited.

- In the State, utilization of public health institutions in general is found to be good. Analysis of HMIS data on service delivery parameters for last three years also depicts an overall increasing trend except for delivery where there is a slight decline in trend. All the facilities visited were found with the NCD clinics having dedicated staff.

- State has already been doing the DH strengthening activities since 2008. For the same, uniformly most of the DHs are taken-up for strengthening. Financial support of Rs 168.91 Crore has been provided to the state since 2008 under NHM.

- In order to provide specialty treatment to rural public in the districts where there are no Government medical colleges are functioning, 15 Districts hospitals were provided special with OP departments at a total cost of Rs.200.00 Lakhs. In addition, 104 CEmONC centres have been established in 29 district and sub district hospitals to strength the Maternal and Child Health care services.

- All the facility visited had adequate drugs and consumables with management of minimum & maximum stocks levels. In the

warehouse proper stacking of drugs and consumables above the ground level in shelves were available. State system of Drug and logistics management through TNMSC has effectively been able to reduce the OOPE on drugs in the State. Drugs are procured through State Nodal agency – TAMPCOL, Chennai. Drugs are supplied on Quarterly basis.

- In all the facilities visited in both the districts, diagnostic services are available 24X7 and are free of cost except for CT & MRI. State model of providing Free Diagnostics Services is completely run by Government through TNMSC. During exit interviews with patients and community interactions as well, it was found that beneficiaries were not incurring any OOPE on diagnostics (Except for CT & MRI) while availing the public health services.

- State has 78 dialysis machines. Dialysis services are provided free of cost in MC & DHs.

- State has well-functioning blood banks (88) and Blood Storage Units (224) with adequate staff. HR in the Blood Banks and BSUs is recruited & supported by "State Blood Transfusion Council- SACS" & respective DDHS. Blood banks are licensed by State Drug Controller and monitoring for ensuring quality is with TN Society for AIDS Control (TNSACS). Blood banks visited in the facility are having necessary IT logistics and are well connected with internet. On daily basis, the data of utilization is being uploaded on the software of TNSACS and is available on public domain. But the utilization and availability status of private blood banks are not captured in the software.

- Average time taken to issue the blood in an emergency is 10 to 15 minutes, while for elective procedures it is one hour. If the blood remains unutilized in the department, where requisitioned, there exists policy guidelines to dispose it off in the department concerned. Display of SOPs & Protocols in blood banks needs improvement.

- In the State there are total 1411 AYUSH co-located facilities available. Under NHM support for 475 AYUSH doctors, 424 Pharmacists and 546 (therapeutic assistants and male health workers) is being provided.

- In the State 108 Ambulances and Emergency services is working well. In the State, 811 ambulances (108) are functional. For addressing neo-natal emergencies, state has taken an initiative under which 65 "neo-natal ambulances" are being operationalized.

- In tribal areas, state has also operationalized the 78 four-wheel ambulances. Further to address the inaccessibility issues State has operationalized 22 bike ambulances which are utilized for providing initial first-aid and stabilizing the patients. Out of total calls received in 108, 24% of the calls are from pregnant women. Average response time in rural areas is 14 minutes and in urban areas is 11 minutes. On the basis of location GPS fitted in the vehicles and GIS mapping, specialized cell in the 108 call centre, maps the need in the grid system. State has done an analysis of data on road accident for dynamic allocation of ambulances on real-time basis to reduce the response time.

- The State has 338 MMUs, called Hospitals on Wheel, and operational in 31 districts. Micro plan is being prepared and made available to the community that leads to good utilization of its services. The inter-sectoral coordination (between health and ICDS department) in state enables its outreach to community effectively. MMUs are equipped with auto –analyzer and on and average OPD per day was observed 85 cases.

- The State has adequate infrastructure and man-power (Engineers) for Bio-Medical Equipment. At present, TNMSC is looking after it. However, the State has not rolled out the National Guideline of Comprehensive Bio-Medical Equipment Maintenance.

- The mapping of all the bio-medical equipment has been done and they have been classified as A, B1 and B2. The

state has developed a very good system of maintaining the equipment. The maintenance of equipment of A and B1 is managed by TNMSC, which is available at Tertiary level care institutions. For B2 categories equipment, TNMSC has fixed the Comprehensive Annual Maintenance Contract charges for 7 years after the warranty period of three years is over. The concerned Departmental HODs are taking care of maintenance of these equipment by engaging the Bio Medical engineers working at District Hospitals or Medical Colleges Hospitals.

- The State has entered into partnership with GVK-EMRI for managing 108 Ambulances and Emergency services and Bio-Medical Waste management services to different agencies at district level.

- 20 special Tribal MMUs for outreach services are operational in tribal area under PPP mode.

Tripura

- No facility was found running in a rented/leased space.

- The state has selected four District Hospitals in the state for DH Strengthening initiative. However, no evidence for planning/progress could be noticed during the visit.

- There is an IT based system for indenting and supply chain management, however there is no quality assurance system in place like prescription audit and grievance redressal system. Instances of stock outs of IFA, Albendazole, OCPs observed.

- Availability of diagnostic services at the facility was fewer in number compared to the list mentioned in National Diagnostics Service initiative (23vs 57). State needs to implement National Free Diagnostic Service Initiative on priority.

- State has shortlisted a services provider to provide comprehensive dialysis services in each district of the state.

- Blood services were available at District and Sub Divisional Hospital in both Gomati & Dhalai.

- However, at Dhalai, only Blood Storage Unit (BSU) is available at the DH which must be upgraded to a blood bank.

- Tripura state has adequate number of transport vehicles for each facility; however these transport vehicles cannot be labelled as ambulances. These vehicles need to be equipped with basic lifesaving amenities and a toll free number. The State should pay emphasis on improving the ambulance service to patients. There is no availability of 102/108 ambulances.

- The State has provision of Cash reimbursement (Rs. 500 to Rs. 1000 reimbursed in cash/ cheque) for referral transport to Pregnant Women

- The inventory mapping has completed and uploaded on NHM website. The state has recently chosen a service provider for Comprehensive Bio –Medical equipment maintenance. It is yet to be implemented in district or below district level. There are still many dysfunctional equipment available in facilities as observed by CRM team.

- The State entered into partnership technology intensive programme like telemedicine, teleopthalmology and teleradiology services (Free diagnostic) and Biomedical equipment maintenance.

Uttar Pradesh

- State has implemented "Free Drugs initiative". EDL drugs list are available at almost all facilities visited and list of available drugs is displayed publically.

- Online Drug Procurement and Inventory Contract System (DPICS) have been functional up to district level and are being used for indenting and distribution. All the District Hospitals are separately connected through software for submitting online indent while below DH level facilities submit their indents manually to District Drug store. At district level, drug samples are being

collected by Drug Inspector and tested. During exit interviews with patients and community interactions as well, it was found that beneficiaries were not incurring any OOPE on drugs while availing the public health services.

- Majority of Essential diagnostic tests as per free diagnostics initiative, are being provided in the laboratory of the District hospital/CHC. During exit interviews with patients and community interactions as well, it was found that beneficiaries were not incurring any OOPE on diagnostics while availing the public health services.

- There is only one Blood bank and a Blood storage unit in Gonda district & four blood banks (one government and 3 private) and 3 blood storage units in Firozabad. No BSUs are functioning in both the districts because of infrastructure and manpower requirements. Blood banks in both the districts are functioning without License which is an area of concern.

- Display of SOPs & Protocols in blood bank at Firozabad is good. Blood is being collected through camps from volunteers as well as from patients' relative as replacement. Blood processing Charges is being taken from patients as decided by U.P Government.

- AYUSH facilities are available at District Hospital and CHC. Either Ayurveda, Unani or Homeopathy systems of medicine are available. AYUSH drugs are being procured through District drug store. Involvement of AYUSH doctors is considerable e.g. many APHCs are being run by AYUSH doctors.

- 108 and 102 Ambulance services are working well with sufficient utilization.

- The Comprehensive Bio –Medical Equipment Maintenance Programme need to initiated across state up to District and below facilities level

- The State entered into partnership for a Bio medical waste management.

TOR 2 | RMNCH+A

OBJECTIVES

- To assess the planning of RMNCH+A, alignment with RMNCH+A 5x5 Matrix based upon gap analysis and prioritization for continuum of care based upon utilization and delivery points.
- To review delivery and quality of PPIUD services, JSY & JSSK entitlements, establishment and functioning of SNCUs, NBSUs, NBCCs, NRCs, RBSK screening, immunization, Alternate Vaccine Delivery arrangements, Maternal and Child Death Review, organization of AFHS .
- To oversee community level care arrangements for Home based new born care, safe delivery at home through SBA, advance distribution of Misoprostol, Iron Supplementations, Adolescent Health Days, Peer Educator and AH counseling etc.
- To review the preparedness for implementation of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

National Overview

1. RMNCH+A Strategic approach

The RMNCH+A strategy was launched in 2013 and it aims to address the major causes of mortality among women and children, through a continuum of care approach. The strategy also aims to address the delays in accessing and utilizing health care and services. In order to streamline the efforts certain priority interventions under each thematic area have been identified and States are expected to plan for service delivery keeping in view a systems approach to RMNCHA care. At national level the status of various components are as follows:

a. Reproductive Health

a.1. Promotion of PPIUCD services (particularly at high case load facilities)

This is one of the priority areas. Currently district hospitals are the most reliable source for provision of this service. Of the total IUCDs inserted in various public institutions across India, 28.5% are PPIUCDs. States/UTs reporting relatively high percentage of PPIUCDs are Tripura (63.5%), Puducherry (50%), Chandigarh (49.5%), Delhi (53.3%), Madhya Pradesh (46%) and Lakshadweep (66.7%). Further, there are 11 more States (Assam, Bihar, Haryana, Jharkhand, Karnataka, Maharashtra, Odisha, Rajasthan, Sikkim, Tamil Nadu and West Bengal) that have reported a

higher percentage of PPIUCD insertion as compared to the national average. It must be noted that the latest round of NFHS does not provide information on PPIUCD as it clubs data on IUD and PPIUD.

a.2. Interval IUCD at Sub Health Centres on fixed days

As per the HMIS, the IUCD insertions per 10,000 unsterilized couples [during 2016-17] stood at 278. Some of the better performing States in this regard are Tamil Nadu (427), Punjab (421), Rajasthan (467) and Madhya Pradesh (327). The high TFR States – Uttar Pradesh, Bihar and Chhattisgarh- reported a rate of 219, 202 and 279 respectively. Currently, 51% of total IUCD insertions are happening at Sub Health Centres. Bihar (57.5%), Chhattisgarh (64.1%), Gujarat (66%), Himachal Pradesh (66.8%), Jharkhand (49.2%), Madhya Pradesh (46.6%), Maharashtra (49.7%), Mizoram (40.8%), Odisha (47.4%), Punjab (61.5%), Rajasthan (47.4%), Uttar Pradesh (63.3%), Uttarakhand (68.3%) and West Bengal (58%) are amongst the better performing States in this regard.

a.3 Strengthening safe abortion services

These services are yet to be institutionalized at sub-district levels and district hospitals remain the main provider for safe abortion services. HMIS analysis for 2016-17 puts the total number of reported abortions at 5,63,232. Of these 235118 (41.7%) were conducted in public institutions and 190906 (33.8%) in private health facilities, while the information on access of care for about 1,37,208 (24.3%) abortions were not captured by the system. Elements pertaining to counselling services need strengthening too.

a.4. Maintaining sterilization services

Women continue to bear an uneven burden of sterilization. For instance, in 2016-17 of the total 5,25,727 sterilization procedures, only 6.6% were male sterilization operations. Further, sterilization camps continue to be held without the desired levels of privacy and clinical safety. There is an urgent need to institutionalize a rights based approach to reproductive health in general and on terminal methods in particular.

b. Maternal Health

b.1. Use of MCTS for early registration of pregnancy and provision of full ANC

During 2015-16, 60.9% pregnant women had their ANCs in first trimester, and 73.5% reported 3 or more ANC visits. While this is an encouraging trend, the concerns related to quality of care during ANCs and identification of high risk mothers along with rigorous follow up mechanisms persist. 63% of the health facilities in the country report to be generating and using work plan of MCTS.

b.2. Detect high risk pregnancies and line list and manage severely anaemic mothers

1.92 % of total ANC registrations were identified as severely anemic (HB <7) of which only 2% were treated. Given the high percentages of anemia that is often quoted by various surveys, there appears to be an underreporting of severely anemic women. The current CRM observes that the line listing of high risk women is not undertaken in the States of Nagaland, Delhi, Tripura, Uttar Pradesh, Himachal Pradesh, Bihar, Arunachal Pradesh. The situation gets complicated when one considers that only 9% of health facilities are delivery

points of which only 14% (2712 health facilities) are FRUs.

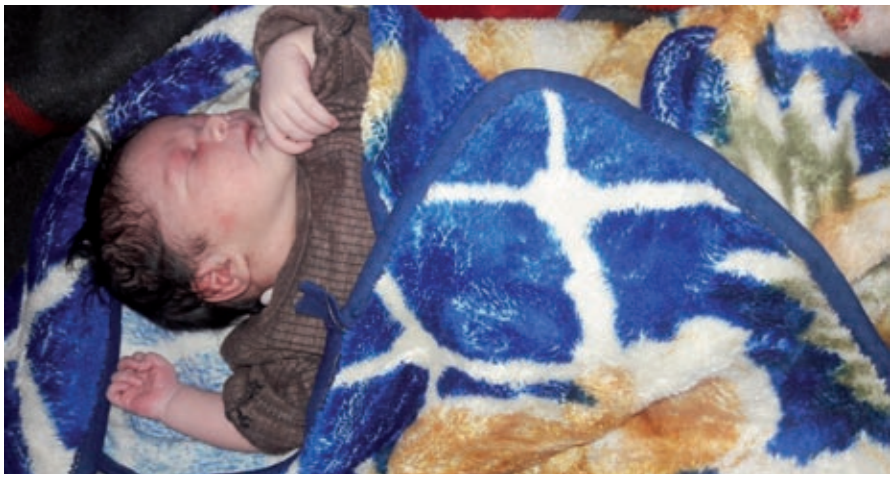
b.3. Review maternal, infant and child deaths for corrective actions

In order to strengthen the accountability and address the systemic issues involved in maternal, neonatal and child death it is important that each such death be reviewed. However, the 10th CRM has observed issues related to underreporting and lack of follow-up on death reviews and these are detailed later in the section.

c. New Born Health

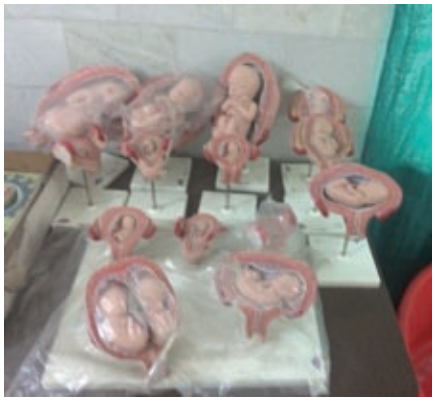
c.1. Early initiation and exclusive breastfeeding

With the national average of 44.6 percent for early initiation in India, early initiation of breastfeeding in one hour varied from the lowest of 14% in Jammu and Kashmir to the highest of 94% in Mizoram. In most States of central and eastern region the extent of exclusive breastfeeding was low, except in Odisha (76%) where for majority of the children the breastfeeding was initiated within an hour of birth. However, in all the States from southern region and north-eastern region, with the exception of Tripura, majority of the children were breastfed within one hour of birth. Though, there is a variation in the extent of early initiation of breastfeeding in all the States, 80 percent or more children were fed with colostrum. Further, more than 58 lakhs newborns have been visited by ASHAs in 2014-15, whereas in first quarter of 2016, around 18 lakhs newborns have been visited by ASHAs.



c.3. Essential New-born care and resuscitation services at all delivery points

602 Special Newborn Care Units (SNCUs) have been set up in district hospitals and medical colleges to provide round the clock services for sick newborns. More than 7.5 lakh babies were treated at SNCUs in 2014-15. 2,228 Newborn Stabilization Units (NBSUs) at the level of FRUs and 16,968 Newborn Care Corners (NBCCs) at delivery points have been operationalized. SNCU online reporting system has been established in 16 States and more than 400 facilities are now reporting online. However, some of the 10th CRM States where shortages of new-born care facilities (particularly NBSUs and SNCUs) was observed include Arunachal Pradesh, Delhi, Madhya Pradesh (District Dindori), Bihar (District Siwan), Himachal Pradesh (Solan and Karsog), Jharkhand (no SNCU in both Districts), Kerala (District Iddukki), Nagaland (no SNCU in any HPDs, no NBSU in District Tuensang), and Tripura (no SNCUs in Districts visited).



d. Child Health

d.1. Diarrhoea management at community level using ORS and Zinc

As per available data from Rapid Survey On Children 2013-14, only 12.6% children (aged 0-59 months) with an episode of diarrhoea in preceding 15 days received ORS and Zn. The 10th CRM observed adequate supplies of ORS and Zn for diarrhoea control in Andhra Pradesh, Chandigarh, Delhi, Gujarat and Tamil Nadu. However, in Arunachal Pradesh none of the

ASHAs or facilities that were visited had stock of ORS and Zinc tablets.

d.2. Full immunization coverage

65.3% of children aged 12-23 months were fully immunized nationally (RSOC 2013-14). The latest trends as per NFHS 4 reveal that Bihar has shown maximum increase of 28.9 points, in percentage of fully immunized children, from 32.8% in NFHS 3 to 61.7% in NFHS 4. Meghalaya too has reported an increase from 32.9% (NFHS 3) to 61.5% (NFHS 4) and Sikkim improved 69.6% to 83%. Amongst the current CRM StatesTamil Nadu, Maharashtra, Uttar Pradesh and Gujarat reported good coverage of all vaccines, with availability of all zero doses at the field level.

d.3. RBSK

Under this intervention, 10.66 crore children have been screened (FY 2014-15)by the 9,774 teams, and 51.78 lakh children have been referred for management of the '4 Ds'. Further, 92 DEICs have been established till date in the country, with 41 medical colleges having been trained to handle birth defects surveillance. The 10th CRM has observed that Tamil Nadu, Tripura, and Maharashtra were implementing the RBSK programme relatively better. Key challenges observed during the CRM have been detailed later in the section.

e. Adolescent health

32 batches of regional ToTs on PE programme have been conducted by 6 identified National Training Partners till December 2016. However, a high attrition rate of Peer Educators is posing a challenge. Further, the average monthly coverage of adolescents under the WIFS programme was 25% (with 28% in-school and 13% out of school coverage). 7,381 AFHCs have been made functional across the country and linkages have also been established with Integrated Counselling and Testing Centres (ICTC) for management of HIV/

AIDS and testing and treatment of RTI/STI cases. In addition to 1,402 adolescent health counsellors working in the primary care health facilities, around 753 ICTC counsellors (in 213 RKSK districts) are also providing Adolescent Health counselling services. However, the 10th CRM observed an underutilization of services provided at the AFHCs in the States of Andhra Pradesh, Arunachal Pradesh, Bihar, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Kerala, Nagaland and Tripura. Moreover, the counselling services provided were observed to be limited to nutrition, sexual and reproductive health and dermatological issues. Stock out of sanitary napkins under Menstrual Hygiene Scheme (MHS) was observed in the States of Arunachal Pradesh, Bihar, Jammu & Kashmir and Maharashtra.

Key Findings

1. RMNCH+A Planning and Monitoring

States that were observed to have better planning of services under various components of RMNCHA include Tamil Nadu, Gujarat and Delhi. Uttar Pradesh and Delhi also reported adequate delivery points as per population norms. Good awareness on RMNCHA components was observed amongst service providers in Jharkhand. Development partners were observed to be supporting the monitoring of services in Arunachal Pradesh and Nagaland. The challenges in RMNCHA planning and implementation were observed to be a) inadequate orientation of district officials (e.g. Arunachal Pradesh, Bihar, Madhya Pradesh), b) inadequate functionality of First Referral Units (e.g. Andhra Pradesh, where only 42% of the FRUs are functional), c) lack of essential RMNCHA drugs and supplies in several instances (e.g. lack of drugs for medical abortion in Maharashtra; Kerala), and d) inadequate monitoring of RMNCHA services (e.g. Madhya Pradesh, Nagaland).

2. Maternal Health

2.1 Antenatal Care

Quality ANC services were observed to be provided in the State of Tamil Nadu. Jharkhand, Gujarat, Chandigarh, Kerala and Andhra Pradesh reported maintaining line listing of high risk pregnancies and severe anemia. In most other States antenatal care, particularly at the level of Sub Health Centers, is deficient either a) in terms of range of services (e.g. Tripura, Nagaland, Kerala, Chandigarh, Jharkhand), b) in identification and line listing of high risk pregnancies (e.g. Nagaland, Delhi, Tripura, Uttar Pradesh, Himachal Pradesh, Bihar, Arunachal Pradesh) and c) in orientation on newer guidelines -such as those on Gestational Diabetes Management, Calcium supplementation, deworming during Pregnancy, Screening for Syphilis/HIV- and protocols (e.g. Andhra Pradesh, Arunachal Pradesh, Himachal Pradesh, Kerala and Nagaland). Incomplete records in MCP cards were observed in the States of Uttar Pradesh and Nagaland.

2.2 Intra-natal and postnatal care

It was observed that inthe States/ UTsofDelhi,Chandigarh,Arunachal Pradesh, Jammu & Kashmir, Bihar, Jharkhand, Kerala (District Idduki) partographs were not used in the labour rooms. While the availability of institutional delivery services was largely limited till CHCs and District Hospitals in Arunachal Pradesh and Nagaland; an under-utilization of delivery services at peripheral health facilities was observed in Himachal Pradesh. For instance, about 10-30% of targeted institutional deliveries were being conducted at health facilities below block level, thus overloading the zonal hospitals and Medical College Hospital. In districts where high home deliveries were observed (e.g. Dindori in Madhya Pradesh and Mon in Nagaland), the distribution

of misoprostol is yet to be institutionalized. Concerns related to high caesarean section rates in the UT of Chandigarh (25-30%) and in States of Kerala (51%), Jammu & Kashmir (33%) persist. Preference for private sector was observed in the Andhra Pradesh and Kerala (about 70% of deliveries in private sector) as well as in Delhi, where 59% of deliveries are being conducted in privates sector.

2.3 Implementation of Janani Suraksha Yojana and Janani Shishu Shuraksha Karyakaram

While States have initiated steps towards online payment of incentives under JSY, the progress in this regard is relatively slow. For instance, in Andhra Pradesh only 5 districts (out of 13) have rolled out direct benefits transfer. In States of Himachal Pradesh, Maharashtra and Uttar Pradesh the payments are being conducted through account payee cheques. Further, instances of delay in the payments have been reported from Arunachal Pradesh, Nagaland, Delhi (Shahdara), Madhya Pradesh (District Ratlam), Tamil Nadu (DH Namakkal) and Uttar Pradesh. Cash payments were observed to be made in Nagaland and Arunachal Pradesh. Services under the JSSK program have now streamlined to a large extent. However, certain challenges that persist include, a) low awareness in tribal/vulnerable population groups (in Kerala, Jammu & Kashmir, Tripura, Maharashtra), b) lack of assured drop back services to postnatal mothers (in Uttar Pradesh, Andhra Pradesh, Chandigarh, Jammu & Kashmir, Delhi, Bihar, Gujarat, Nagaland), c) relatively lesser awareness on entitlements of infants and d) non-institutionalization of grievance redressal mechanisms.

2.4 Maternal Death Review

States with relatively better mechanisms of maternal death review are Tamil Nadu, Maharashtra, Chandigarh and Gujarat. Tamil Nadu is also in process of establishing Maternal Near Miss Review. In most other States gaps relating to maternal death review persist. For instance, Madhya Pradesh, Delhi, Bihar, Jharkhand, Kerala, Nagaland have not reported any maternal deaths in current year which is highly unlikely. Further, in the States of Uttar Pradesh, Jammu and Kashmir, Madhya Pradesh, Jharkhand and Bihar the reported deaths are not being reviewed by the district MDR committee headed by District Magistrate. Community based MDR was observed to be weak in Tripura and Kerala.

2.5 Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

Barring the States of Bihar and Nagaland, all other States were observed to have undertaken activities under thus scheme. However, involvement of private providers was in limited numbers in Chandigarh, Jammu & Kashmir,

Delhi, Himachal Pradesh and Tripura. A relatively better involvement of private providers was observed in Maharashtra.

3. Child Health

3.1 Implementation of New Guidelines

It was observed that in some of the States (e.g. Maharashtra, Delhi, Madhya Pradesh, Gujarat and Himachal Pradesh) recently launched guideline such as use of antenatal Corticosteroids in preterm labour and use of Gentamicin by ANMs for management of sepsis were issued as well as implemented at district and sub-district level. However, in the States of Kerala, Arunachal Pradesh, Jammu &Kashmir, Tamil Nadu, Jharkhand, Tripura and Uttar Pradesh, the implementation of these guideline yet to be scaled up.

3.2 Kangaroo Mother Care

KMC was observed to be promoted by providers in the States of Andhra Pradesh, Tamil Nadu, Gujarat, Maharashtra, Tripura and Delhi; while a relatively limited knowledge on KMC (among providers) was observed in Bihar. Largely spate space for KMC/ KMC wards were available only at the level of district hospitals.

3.3 Quality of services in SNCUs, NBSUs, NBCCs & NRCs

Mortality rate in SNCUs ranges from 1-3% in Tamil Nadu to as high as 27% in Uttar Pradesh (Gonda District). Birth asphyxia, pre-maturity and neonatal sepsis have emerged as major reasons for admissions to SNCUs across various 10thStates. Further, irrational use of anti-biotic in SNCUs was reported from Kerala and Uttar Pradesh. Adequate number of facilities with trained human resources and infrastructure for new-born care were observed in Andhra Pradesh, Gujarat, Maharashtra. Some of the CRM States where shortages of new-born care facilities (particularly NBSUs and SNCUs) was observed include Arunachal Pradesh, Delhi, Madhya Pradesh (District Dindori), Bihar (District Siwan), Himachal Pradesh (Solan and Karsog), Jharkhand (no SNCU in both Districts), Kerala (District Iddukki), Nagaland (no SNCU in any HPDs, no NBSU in District Tuensang), and Tripura (no SNCUs in Districts visited). Maharashtra and Jharkhand were observed to have relatively better utilization of NRCs as compared to other States in the country. However,

there is a scope of improvements in counselling services, referrals and monitoring in Jharkhand. Key concerns with respect to NRCs include; a) low bed occupancy rate (Andhra Pradesh, Arunachal Pradesh), b) non-adherence to guidelines (Chandigarh), c) human resource shortage (Delhi), d) limited linkages with anganwadis (Madhya Pradesh, Uttar Pradesh), and e) low referrals from community (Andhra Pradesh).

3.4 Implementation of Infant & Young Child Feeding practices including Mothers' Absolute Affection (MAA)

Community awareness on IYCF practices was good but service providers were unaware about the MAA initiative in Arunachal Pradesh. Counselling to the community for IYCF practices by service providers needs strengthening in Madhya Pradesh, and Gujarat. Tripura reported a relatively better implementation of early initiation of breast feeding practices.

3.5 Efforts on Diarrhoea (IDCF) and ARI control programme, Implementation of National Iron Plus Initiative, Deworming and Vitamin A supplementation programme

Adequate supplies of ORS and Zn for diarrhoea control was reported in Andhra Pradesh, Chandigarh, Delhi, Gujarat and Tamil Nadu. However, in Arunachal Pradesh none of the ASHAs or facilities that were visited had stock of ORS and Zinc tablets. Tamil Nadu reported good implementation of de-worming programme in the State. Low uptake of iron folic syrup/tablets to children was reported from Andhra Pradesh, Chandigarh, and Nagaland. Uttar Pradesh reported stock-outs of iron folic syrup/tablets at the community level. Non- procurement of iron folic syrup/tablets and Vitamin A was reported as a deterrent to implementation of NIP Initiative in Himachal Pradesh.

3.6 Progress in implementation of Rashtriya Bal Swasthya Karyakaram

Tamil Nadu, Tripura, and Maharashtra were observed to be implementing the RBSK programme relatively better. Key challenges pertaining to the program includes; a) non-adherence to guidelines while screening of children (Bihar, Nagaland, Jammu & Kashmir), b) lack of microplanning (Arunachal Pradesh), c) poor referral & follow up mechanisms (Himachal Pradesh), d) limited involvement of schools in RBSK (Kerala), and lack of DEICs in various districts of some States (Madhya Pradesh, Gujarat, Nagaland, Uttar Pradesh and Jharkhand).

3.7 Implementation of Child Death Review

The initiative was observed to be well implemented in Tamil Nadu and Himachal Pradesh. Chandigarh, Arunachal Pradesh, and Delhi are yet to implement Child Death Reviews whereas, Madhya Pradesh has started CDR for deaths reported in SNCU only.

4. Family Planning

4.1 Status of Quality Assurance Committees

District Quality Assurance Committees (DQAC) were observed to be formed in Delhi, Gujarat, Nagaland and Bihar and operational in most of the districts. However, the frequency of meetings held was not regular in Madhya Pradesh and Tripura. Further, most of these committees are yet to act as

4.2 Adequacy & quality of family planning services

Supplies related to spacing methods, particularly condoms and OCPs were in shortage in Jammu and Kashmir, Jharkhand and Arunachal Pradesh, whereas they were adequately available in Gujarat, Maharashtra, Tripura, Delhi and Uttar Pradesh.Barring Tamil Nadu and Gujarat, all States reported availability of Pregnancy Test Kits (PTKs) at sub-health centres. Bihar reported a supply of PTKs after a gap of three years. IUCD and OCPs continue to be mainstay of the spacing methods being made available in public health facilities across all States. Women continue to bear the burden of terminal methods of contraception. Further, the Non Scalpel Vasectomy (NSV) services were reported to be provided in very few DH level facilities and uptake being particularly low in Bihar, Himachal Pradesh, Madhya Pradesh, Uttar Pradesh, Delhi, Tamil Nadu and Nagaland. Madhya Pradesh reported acute shortage of trained human resources for conducting NSVs and most cases in Tamil Nadu were usually performed in camps. At sub-district level, most States were observed to be providing IUCD services at select SHCs (L1 centres). However, and in Kerala the IUCD Insertion was primarily being carried out at Taluka level. Follow up on patients was inadequate in Bihar and Andhra Pradesh and follow up records were not maintained in these States.

4.3 Quality of counselling services

The counselling services were observed in almost all the 10th CRM States (with variations in protocols adopted among the States). System and protocols for this service were weak and requires streamlining and strengthening in Bihar, Chandigarh, Gujarat, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Nagaland, Tamil Nadu, Tripura and Uttar Pradesh.

4.4 Involvement of ASHAs and ANMs

Limited involvement of ASHAs, ANMs was observed in promotion of IUCD & PPIUCD services in Tamil Nadu, Tripura, Andhra Pradesh and Arunachal Pradesh. Involvement of ASHAs in implementation of family planning services like home Delivery of Contraceptives, Ensuring Spacing of Births (ESB), PTKs etc. varied across the States and UTs. They were observed to be actively involved in home delivery of contraceptives in Andhra Pradesh, Gujarat and Maharashtra while reported almost inactive in this regard in Arunachal Pradesh and Chandigarh.

5. Comprehensive Abortion Care (CAC)

These services were limited to District Hospitals in most States and the provision of abortion services was not observed in majority of sub-district level facilities.

6. Immunization

Chandigarh, Maharashtra, Gujarat and Jharkhand have reported good planning and organization of VHND sessions. While in Himachal Pradesh ANMs were observed to be using due-lists generated from MCTS; in Andhra Pradesh the due lists generated from ANMOL were used by very few ANMs and most of the reporting formats were being filled manually. Microplanning

of sessions needs strengthening in Andhra Pradesh, Madhya Pradesh, Jammu & Kashmir (Ramban), Nagaland, Arunachal Pradesh and Uttar Pradesh. There is a need for capacity building of Village Health Nurses in Tamil Nadu regarding immunization schedule, newer vaccines and vaccination schedule for unvaccinated children presenting in different age groups. State Task Force & District Task Force were observed to be in place in Bihar, Tripura, Tamil Nadu. However, the mechanisms related to AEFI need to be strengthened in Himachal Pradesh (AEFI kits not available), Jammu & Kashmir, and Madhya Pradesh (in terms of training of ANMs in identification, management & reporting of AEFI). Cold chain maintenance has been reported to be well established in the States/UTs- Bihar, Chandigarh, Delhi, Gujarat, Himachal Pradesh, Jharkhand and needs further strengthening in the States of Nagaland and Tripura. EVIN software was observed to be well implemented in the States of Gujarat and Uttar Pradesh. IEC to mothers on key messages on immunization needs strengthening in the States of Arunachal Pradesh, Gujarat and Jharkhand.

7. Rashtriya Kishor Swasthya Karyakram (Adolescent Health)

Underutilization of services provided at the AFHCs was observed in the States of Andhra Pradesh, Arunachal Pradesh, Bihar, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Kerala, Nagaland and Tripura. Moreover, the counselling services provided were observed to be limited to nutrition, sexual and reproductive health and dermatological issues. There was also lack of visibility of IEC material related to adolescent health in the health facilities (except in Madhya Pradesh and Tamil Nadu). Under WIFS programme, unavailability of stock was observed in the States of Arunachal Pradesh, Bihar, Chandigarh, Jammu & Kashmir and Uttar Pradesh. Convergence between the departments of Health, Education and WCD lead to poor reporting on IFA coverage low awareness regarding the benefits of IFA tablet consumption among the beneficiaries in the States of Delhi, Kerala, Nagaland and Tripura. Stock out of sanitary napkins under menstrual hygiene scheme was observed in the States of Arunachal Pradesh, Bihar, Jammu & Kashmir and Maharashtra. The uptake of sanitary napkins was low due to no sensitization meetings for adolescents on Menstrual Hygiene Management (MHM) by ASHAs and poor quality of sanitary napkins. The peer education component under RKSK is yet to take off in all the States except for Tamil Nadu. All the States (except for Tamil Nadu) are in process of training the ANMs on Peer Educator manual under RKSK. This would be followed by training of ASHAs and peer educators.

Recommendations

1. Principles of decentralised and differential planning need to be strictly adhered to while planning RMNCH+A implementation in States. This is vital in order to ensure availability of assured RMNCH+A services.

2. Facility specific road-map, along with SOPs for all procedures is required to be generated and effectively implemented. This includes establishing audit mechanisms, defined roles and responsibilities of service providers at all levels of care, and strict adherence to quality assurance guidelines.

3. Information generated from available sources and evidences generated from ground level must be utilized for effective RMNCH+A strategy planning and implementation. Strategic action plans such as State level new-born action plans should reflect information gathered from review mechanisms and operational & implementation research.

4. Newer initiatives such as PMSMA, MAA, etc. need to be better implemented, along with strengthening the earlier initiatives for RMNCH+A

health outcomes. States should explore possibilities of involving academic institutions, professional bodies and private sector to better implement these initiatives.

5. Strong linkages with community are missing and must be ensured through involving structures such as Village Health and Sanitation Committees (VHSNCs)/ Panchayati Raj Institutions (PRI), Rogi Kalyan Samitis (RKS), etc.

6. Training and capacity building of service providers needs to be taken on priority. This includes focussed attention on specific programmes such as RKSK and RBSK.

7. Integration and collaboration within ongoing RMNCH+A programmes, such as RBSK and RKSK, to expedite programme implementation must be considered by States.

8. Inter- departmental coordination between Departments of Health, Education and WCD has been a challenge and needs to be meticulously dealt with. There are many schemes/initiatives (e.g. WIFS and de-worming programme) which can work effectively with better inter-departmental coordination.

9. Robust planning for fixed day family planning services is a must at all levels. States need to devise innovative approaches to ensure better coverage of family welfare schemes through community involvement.

10. Up-scale and replication of existing models of supply chain management for drugs & logistics should be a priority. Many States have IT platforms for managing supply chain which need to be adapted by others according to need.

State Findings

1. Andhra Pradesh

i. Improved utilization and uptake observed for HDC schemes- ASHAs are actively involved in social marketing services to provide Oral Contraceptive Pills, Condoms and Emergency contraceptive pills by conducting door to door visits.

ii. PPIUCD training has not been rolled out even after training of master trainers, only few facilities provide PPIUCD services and that too is low against total deliveries, inconsistencies observed in consent taking of the beneficiaries and no follow up records being maintained.

iii. Despite a total of 155 functional AFHCs in the RKSK districts of the state, the footfall at the AFHCs remains below satisfactory. There was no dedicated room for AFHC at the visited health facilities. At the AFHCs, ICTC counsellors have been given the additional charge of counselling the adolescent clients which is not been done.

iv. At the state level the stock of IFA tablets has been procured in February 2016. No stock outs have been reported by any of the districts in the state for the last six months. In FY 2015-16, total coverage under WIFS was reported to be 81% at the state level; Krishna and Kaddapa districts reported 82% and 68% WIFS coverage respectively.

v. JSY and JSSK programs are fully operational; Drop back facility for mother and child after institutional delivery (Thalli Bidda Express) is being successful implemented and highly popular in the community.

vi. Health service providers needs more hand holding for use of partograph and identify major indications that require immediate clinical interventions.

vii. Adequate NBCC, NBSU and SNCUs are in functional state; however the state should now focus on improving the quality of care in its SNCUs.

viii. Adequate supplies of all the child health commodities like ORS, Zinc, vaccines and Vitamin A was reported. Good coverage of TT to

pregnant women, birth dose of Hep-B, OPV zero dose and FI coverage in children.

ix. State reported full immunization coverage of 65% as reported in NFHS-4.

x. Immunization beneficiary headcount is either not done or is done in non-standard formats. Moreover, manual due list (variable columns) is used despite ANMOL (ANM online).

xi. Micro plan made is mostly limited to ANM duty roster on planned immunization sessions. Session planning is not based on injection load.

xii. Under cold chain, there is no adherence to heat/freeze sensitivity guidelines

xiii. Alternate vaccine delivery is not fully functional as yet.

xiv. Injection safety practices were not followed by the ANMs. Also, it was found that the ANMs were not writing date & time of opening the vaccine vials and Vitamin A bottles.

2. Arunachal Pradesh

i. PPIUCD has started at district hospital level (General Hospital) but is rudderless with no one involved in its promotion. Nurses are not trained in IUCD insertions. Constitution of District Indemnity Sub Committee (DISC) as per directions of Hon'ble Supreme Court was not in place.

ii. All the ASHA schemes for family planning like Home Delivery of Contraceptives, Ensuring spacing of births, PTK, etc. are all non-starters.

iii. There was no dedicated room for the AFHCs in the visited health facilities. No proper records and service delivery registers have been maintained at the AFHCs. The footfalls at the AFHCs were found to be very low. There are dedicated AH counsellors at the clinic, however the effectiveness of counselling given to the adolescents is way below satisfaction. Outreach activities by the AH counsellor has not been initiated as yet.

iv. Despite convergence meetings with WCD and education departments at the state and district level, there has been stock out of IFA tablets for last two years. Last procurement of IFA tablet was done in FY 2014-15. District wise coverage of beneficiaries was not available.

v. Only the basic Antenatal Care (ANC) was being providedat the CHCs and districtlevel. None of the facilities visited were maintaining a line list of high risk pregnant women.

vi. Institutional deliveries were being conducted only at the CHC and district level, however Caesarean-section facilitieswithbloodbank(CEmOC)facilitywasavailableonly atGeneral Hospital, East Siang.

vii. It was found that all the beneficiaries were aware about JSY benefits and received amount in the form of cash with some delay in FY 2016-17 due to unavailability of funds.

viii. In the last two quarters of FY 2016-17, only around 60 babies were admitted in SNCU and most of them were low birth weight babies. Although there is no model KMC unit in both the district, however the staff was aware about KMC but not practicing due to lack of guidance and dedicated rooms. Thereis a needfortrainingthestaff posted inthe SNCU to strengthen their capacity to manage sick newborns.

ix. Only Children registered with AWC and schools were being targeted, and MHTs did not have any plan to target non registered children in both the institutions. DEIC is mainly underutilized despite all the required positions in-place.

x. Cold chain management was functional in most of the health facilities visited. However, maintenance of cold chain was not being done at few health facilities.

xi. Full immunization coverage in East Siang was 63%, frequent

dropouts of pentavalent vaccine were observed with no plan to track the drop outs.

xii. There was poor awareness on Mission Indradhanush in both the districts. Micro plan and due list to identify and reach the drop outs was not available.

xiii. There was lag in payment (more than 3 months) of ASHA incentives for full immunization.

All EPI vaccine including IPV and Vitamin-A were in stock at all the health facilities visited. MCP cards are available at all the health facilities; however, complete information of beneficiary and ASHA was not mentioned in the cards. Moreover, separate cards were being issued for ANC and routine immunization. Vaccine stock register was either not available or not maintained properly. Vaccine requirements were not calculated before indenting stocks.

3. Bihar

i. Weak follow up & data of IUCD expulsion not captured. PPIUCD training even though has been completed, 30% of them are trained but still unable to utilize the technique.

ii. HDC- ASHAs are distributing the contraceptives however its reporting requires strengthening. Supplies were available with ASHAs. Lack of counseling is one of the major pull backs of the program, and there are limited end user takers.

iii. AFHCs at health facilities in the district are not set up as per RKSK guidelines. Clinics at the visited health facilities are set up along with family planning clinic, IYCF centre, STD clinic etc. Footfall at the clinics is very low. Moreover, privacy of the visiting adolescent clients at the clinics is highly compromised.

iv. Blue IFA tablets under WIFS program has never been procured at the state as yet. Bihar Medical Service and Infrastructure Corporation (BMSIC) are responsible for the procurement of all the drugs at the state. It was given to understand that by December 2016 the procedure of procurement of IFA tablet at the state will be completed.

v. District has integrated the six services like Family Planning, ANC, PNC, Immunization, Nutrition and Counseling with VHND. ANM, ASHA and Helper are supposed to provide services: BP & Hb. estimation, Urine albumin, vaccination, issue of MCP Cards & Safe motherhood booklet, FP spacing methods, general drugs etc.

vi. High rate of home delivery: There has been an increase of 4% points in full immunization coverage of the state (65.6% in AHS 11-12 to 69.9% in AHS 12-13). IFA was not given due to non-availability. OOPE informed on transportation, diet by the beneficiaries during the sequence of their delivery at health institution.

vii. Routine lab tests and USG are currently being done in private facilities and the community felt that if that these facilities are made available at no cost, this would ensure more mothers to come to the facility

viii. Most JSSK benefits are not being provided to mothers and they are incurring OOP.

ix. SNCU in DH Siwan has radiant warmers and photo therapy unit, but the load is minimal. 30 % of the cases are outborn and are refrred from other PHC or are the sent away cases of private hospitals

x. Early breastfeeding initiation not happening; breastfeeding practices were below par, and the first feed ranged from 2 hours – 10 hours. Knowledge of kangaroo mother care is very poor

xi. NBSUs are not functional at block PHCs. Certain APHCs are conducting deliveries however there is no NBCCs established. MJK Hospital does not have functional radiant warmer.

xii. State and district level task force is in place.

xiii. Open vial policy is being implemented. Micro plan with detailed information was found to be available.

xiv. It was observed that cold storage was maintained effectively; however, the vaccines in the cold store were out of stock. Also, it was found that demand from the ANMs for issuance of vaccine was not being taken at the cold chain points.

xv. It was also observed that the used syringes, vials etc. are not being collected regularly for disposal.

4. Chandigarh

i. Pregnancy testing kits were available at all facilities, laparoscopic sterilization was provided and IEC in family planning was visible in all health facilities visited.

ii. PPIUCD coverage is low at delivery points but the follow up of IUCD/PPIUCD was satisfactory. Door to Door distribution of FP commodities by ASHAs was not introduced.

iii. AFHCs have been established at DH and CHCs but the footfalls at the clinics are very low. At the health facilities visited, post of AH counsellor was vacant for last 6 months only recently a counsellor has joined. No linkages have been established between AFHC, skin and ICTC clinics within the health facility. No proper record on service delivery and client registration has been maintained at the AFHC.

iv. WIFS programme is being implemented through schools, however for last six months there is stock out of IFA tablets in the schools. It was informed that last procurement of IFA tablets was done in December 2015. ERS has been established in the UT.

v. Partograph is being filled up in 30%-40% of cases and out of all staff nurses posted in labor room, very few staff nurses were trained in NSSK and SBA.

vi. Free entitlement under JSSK was being provided to the pregnant women. Free entitlements under JSSK was largely being provided with free drugs, diagnostics, diet during delivery but referral transport for drop back was very poor.

vii. New born Stabilization Units and SNCU were available and functional but Staff nurses were not trained in FBNC & NSSK.

viii. As per the report shared by the UT, all the maternal deaths reported till October 2016 were reviewed. Till October 2016, 12 maternal deaths are reported and reviewed in comparison to 10 maternal deaths reported in 2015-16.

ix. Breast feeding practices is initiated within an hour of birth among the beneficiaries interviewed. NRC was available but it was running in the OPD clinic and not maintained as per GoI guidelines.

x. Under RBSK the record keeping was found to be satisfactory in the schools visited. However, treatment and follow-up of identified cases needs to be strengthened.

xi. Cold chain and alternate vaccine delivery system are established and maintained effectively. It was observed that cold chain handlers were well oriented on open vial policy in the UT. Cold chain equipments such as ILR, deep freezer etc. were well maintained with functional temperature charts and updated records.

xii. VHND sessions are being organized on fixed dates in the villages with support of provision of AVD.

xiii. Birth doses of OPV, BCG and hepatitis-B are being given to the neonates before discharge, however in some cases it is not being update in the MCP cards at the delivery point.

5. Delhi

i. PPIUCD services were found to be provided at all

the delivery points and the provider is incentivized as Rs. 150 per PPIUCD insertion. Achieved 2651 insertions against the target of 6000 in financial year 16-17.

ii. Sterilization camps were conducted for both male and female, by the state.

iii. The Adolescent Friendly Health Clinics in the visited districts are functional once a week on specified hours of the day. It was observed that there is no dedicated room available to run the clinics in the health facilities visited. Moreover, there is no dedicated AH counsellor at the clinic. No information was available on the client load as no records were maintained at the clinic.

iv. The UT reported 18% coverage of beneficiaries under WIFS. Despite convergence meetings with the education and WCD departments, reporting on coverage of beneficiaries under WIFS is still a challenge.

v. Drugs and diagnostics facilities are provided free. Very few OOPE incidences were noted. Essential commodities under RMNCH+A matrix are available. No stock outs observed (except Calcium in MCD facilities).

vi. Though total ANC registration (145%) is very high against estimated pregnancies (338892), Antenatal checkups (3 ANC Check up, TT administration and IFA distribution) were reported to be low against estimated pregnancies in the State.

vii. Lab services were found to be satisfactory in all the places conducting all the routine tests required for ANC. PPTCT, RTI/STI services are being provided at higher facilities. Skill labs are not found to be functional at any facility.

viii. C-section rate also is very high both at public institutions as well as private institutions in the State (59% at Private Institutions and 22% in Public Institutions against Reported Institutional Deliveries).

ix. Rs. 22.67 lakhs were transferred in the accounts of JSY beneficiaries up to June 2016 which is very less utilization during the current FY 2016-17 compared to previous year's utilization. Reasons cited were beneficiary reluctance, migrant population, lack of documents needed for payments and Adhar based DBT. JSY benefits are not reaching the population especially migrant population.

x. Under JSSK, beneficiaries are getting free medicines and most of laboratory tests, however many of them were making out of pocket expenditure for transport facilities as only 6625 beneficiaries received transport for home to health facility and only 3115 drop back to home out of total 58462 beneficiaries received drugs and consumables during first quarter of the current financial year.

xi. PMSMA day was observed at various facilities providing ANC care. Voluntary private doctor participation was not observed in the visited facilities. High risk cases were identified and attached with red sticker in some facilities.

xii. Tertiary hospitals are providing all the specialized services to newborns and have Neonatal ICUs. Neonatal ICUs are separate for in-born and out-born neonates and have all equipments and adequate manpower to handle all the emergencies including ventilation support. No Newborn Stabilization Unit is found even in high newborn case load facility (LNJP).

xiii. RBSK is not functional, however early intervention centre in SDN supported by NGO is functional which needs to be augmented. DEIC was not found to be functional on account of infrastructure and manpower.

xiv. Cold storage was established at most of the delivery points visited, with effective management of cold chain equipment. No stock out of

any vaccine has been reported in last six months.

xv. Most of the tertiary care health facilities provided vaccines only for the institutional deliveries. ILRs at the visited health facilities had vaccines well-arranged and effectively managed. The staff in the immunization room had adequate knowledge on vaccines and immunization schedule.

xvi. Gaps in service delivery and follow up on immunization in the UT were reported as per MCTS records for BCG, Measles and full immunization status of infants showed only 68%, 19% and 15% coverage respectively.

6. Gujarat

i. Quality of Family Planning Services was found to be good; percentage of sterilization after two children and IUCD after one child is high. PPIUCD insertion needs improvement. Only few facilities are performing.

ii. Availability and utilization of FP commodities – IUCD, condoms, OCPs, ECPs was adequate across all facilities.

iii. It was observed that, the AFHCs at health facility visited have not been established as per RKSK guidelines. Medical officers and ANMs providing counselling services to the adolescents have not been trained in providing adolescent friendly health services.

iv. At the state, procurement of IFA tablets was done in June 2016. None of the district reported stock out of IFA tablets in last six months. On an average the state reported 30% coverage of total beneficiaries under WIFS. At the districts visited, WIFS is being implemented through schools and AWCs.

v. District has adequate no. of health facilities; additionally Chiranjeevi and Bal Sakha Facilities are available.

vi. Antenatal and Post Natal Services are being provided across the facilities. Line listing of High risk pregnancies was observed across all the facilities. Case Sheets with Pantograph present across all the facilities.

vii. FRUs were Functional in the District Navsari. All 4 FRUs were adequately staffed in terms of MOs and Staff Nurses. FRUs have CEmoC trained doctors although they were doing deliveries under supervision of Gynecologist.

viii. Distribution of Misoprostol tabs was observed in the pockets where home deliveries were taking place.

ix. Follow up on corrective action on MDR at the block level was not taking place.

x. C-section rate were found to be very high in Gandhinagar District. However, it is 10% to 12% in Navsari District. Most of the women are going to the CHC/FRU level facilities resulting in degradation of the quality of ANC services.

xi. JSY awareness in the community was very less. JSY details were not found in Mamta Card. JSY payment is done in 7th month of pregnancy which is not in accordance with GoI guidelines

xii. Infrastructure of the SNCU was good in Navsari. SNCU and NBSU were adequately staffed. On line reporting for SNCU was observed. Utilization of SNCU was reported to be limited.

xiii. RBSK teams need strengthening, there are many vacancies especially of pharmacists teams are incomplete and involved in other health activities of the PHCs.

xiv. Cold chain and alternate vaccine delivery system are established and maintained effectively.

xv. All the vaccines were covered under routine immunization. Birth dose vaccine was given to all the newborns reported.

xvi. Micro plan and due list for immunization was maintained by the ASHAs. Incentives for ASHAs on completing full

immunization under RI were up-to date.

xvii. Talukas in the districts were graded on the basis of their immunization performance.

xviii. EVIN software is being utilized across all the health facilities (old chain points) to monitor logistics for immunization.

7. Himachal Pradesh

i. Most of the ANMs at the MCH centre and sub-centers aware of the Expected level of Achievements (ELA).

ii. Under 'Spacing' services, percentage of PPIUCD and interval IUCD insertions was very low against ELA. NSV (male) were very low.

iii. There was lack of privacy at most of the AFHCs visited. At the zonal hospital- Mandi the clinical psychologist and medical social worker are available to provide counselling to the visiting adolescent clients as the AH counsellor at the AFHC are not trained yet. There was no IEC on RKSK available at the AFHC.

iv. WIFS program is functional in the state since 2013 and is well established and implemented throughout the state. Adequate stock of IFA was found at the schools visited. There is supervised ingestion of IFA tablets practiced at all the school visited.

v. The distribution of sanitary napkins is through ASHAs and AWWs. No stock out of sanitary napkins has been reported in last six months. There is good acceptability of the scheme amongst adolescent girls however, there were issues related to poor quality of the napkins as they had low absorption capacity and smaller size, often resulting in leakage.

vi. Himachal Pradesh has shown remarkable progress in terms of maternal health in past years. Apart from social factors, major factors which contributed in reduction of maternal deaths are the improved quality of ANC services, mapping and strengthening of delivery points, ensuring high number of institutional deliveries through effective implementation of JSY.

vii. 10-30% of targeted institutional deliveries are happening in the DP within the block, rest 70-90% happening either outside block/district in higher facilities which shows gross underutilization of peripheral delivery facilities.

viii. PHCs are functioning only as day care centres with no services being given in the nights for emergencies

ix. Incentives for institutional deliveries have not been disbursed in Solan District.

x. PMSMA implementation in the districts includes Identification of HRP & severe anaemia in ANCs is being undertaken, however, their line-listings not being maintained and hence effective follow-up for improving pregnancy outcomes is not being done by the line –mangers during monthly review meetings.

xi. SNCUs are well maintained despite higher bed occupancy rate. Most of the neonates are premature and under-weight. There is follow-up mechanism also developed in SNCUs. SNCUs were functional in both districts.

xii. Training of ANMs in identification and management of AEFI is required. ANMs were found to use EDD (due list) generated from MCTS. ANMs knowledge on injection safety, AEFI response was satisfactory and AEFI kits not available as per the guidelines.

xiii. Cold chain was maintained at all the levels and all vaccines were found to be available at the cold chain points.

xiv. MCP cards were found to be updated however, detailed micro-plans were not available at most of the CHCs and PHCs visited. It was found that the ANM uses the EDD (due list) generated from MCTS for immunization purpose. Moreover, ANMs knowledge

on injection safety and AEFU was below satisfaction. Training of ANMs on these issues is required.

xv. Spot administration of Vit. K and Hep-B vaccine is not being done to the new-borns, it is being given on the following day by the immunization personnel only.

xvi. It was observed that procurement of vitamin-A syrup is a challenge in the state.

8. Jammu and Kashmir

i. Under birth spacing, percentage of birth interval of 3 years and above was 68% (SRS, 2014). Total unmet need of State has decreased from 24.9% to 20.6% (DLHS data).

ii. Spacing Methods have not picked up particularly, IUCD, PPIUCD. IEC on Family Planning was not visible in all health facilities visited.

iii. AFHCs have been established at the DH and CHC but are not fully functional as yet. The footfalls at the AFHCs are very low. AH counsellors are in position at most of the AFHCs visited; however training of these counsellors on providing adolescent friendly health services has not been done yet. No outreach is being conducted by the counsellors to improve the footfalls.

iv. WIFS programme not yet initiated in the state as yet. Procurement of IFA by the state has been completed and supplies dispatched to the district warehouses.

v. Total unmet need of State has decreased from24.9% to 20.6%(DLHS data)

vi. C-Section is reported to be very high not only at the State level (33%) but also more than 46% at MCCH Anantnag, which deserves immediate attention. Labour room is well equipped for conducting normal deliveries and provision of essential newborn care.

vii. Partograph is not practiced even in facilities where SBA trained staff nurses are posted. SBA trained nurses were not posted in labour rooms at all delivery points,.

viii. Poor screening and management was reported by RBSK team with untrained staff in SNCUs and NBSCs.

9. Jharkhand

i. Facility based family planning services like female sterilization, interval IUCD and PPIUCD services were provided mainly through district hospitals and very few CHCs.

ii. Spacing methods like the CC, OCP and ECs were mainly distributed by the Sahiyas (ASHAs). Spacing methods like condom and OCPs were not adequately available across all the facilities. Pregnancy testing kits (Nichchay kits) were available at all facilities including the VHND sites.

iii. AFHCs in both the districts were available at the district hospital and CHCs. It was observed that the clinics at the DH were functioning well as compared to the clinics at the CHCs. The footfalls at the clinics in the health facilities visited were below satisfactory. No proper records and registers on service delivery at the AFHC were maintained at the clinic.

iv. Coverage under the WIFS program is 21% of the target population. Average in school coverage is 24% and out of school coverage is 18% of the total beneficiaries. Last procurement of IFA tablets was done in May 2015. Emergency response system is in place. 100% reporting isn't in place due to lack of support from the education and WCD department.

v. Most of the Staff (ANM and SN) conducting deliveries were trained in SBA and NSSK and have the knowledge and skill in different procedures.

vi. Some issues related to quality of service were observed e.g., properly filling up of the partogram, infection prevention and disinfection

practices by the providers. Partogram was not done for all the cases and in many cases it was not done properly.

vii. Basic lab investigations for ANC were available at DH and CHC level, however the laboratory services were not available at the below CHC level facilities.

viii. Post-partum stay at hospitals ranges from 24 hours to 48 hrs depending on the case load and the bed availability in that particular facility. The post-partum and the ante natal mothers stay together in the maternity ward. The necessary laboratory investigations and drugs are provided to the mothers free of cost.

ix. Free entitlements under JSSK were being provided to the pregnant women and sick infants in both the districts visited. Free entitlements under JSSK was largely being free drugs, diagnostics, diet during delivery and home to facility transport, provided to the mothers.

x. Janani Suraksha Yojana (JSY) payments being made timely through DBT in the health facilities visited.

xi. The maternal death reviews are done by the field staff through verbal autopsy, however its review is not held at the district level by the district level committee. The reporting and review of maternal death reviews need to be strengthened for facility reporting and district level review in both the districts.

xii. Blood Bank/BSU was not available at the DH or any other facilities of Godda district. The head quarter facility of Godda depends on a private blood bank for blood. In the DH Garwa, the blood bank is well functional.

xiii. No SNCU has been established in both the districts. In Godda, there are two New-born Stabilization Units of which one is not functional. It was learnt that complicated cases from CHCs and PHCs are referred to the DH hospital. At DH, no SNCU or NBSU is available and the referred cases are managed in the general ward.

xiv. NRCs are established within the hospital, adjacent to the patient wards. The NRCs are managed by the ANMs, who are trained in cooking, food preparation and counselling the mothers on diet. Proper diet was given to mother and children admitted in the MTC.

xv. In RBSK, the services for identification and referral of cases (0-18yrs) for 4 D's were not properly in place in the state. In both the districts visited, DEICs were not established. There is an urgent need to establish the DEICs for management of the referred children having 4 D's.

xvi. Cold chain and alternate vaccine delivery system are established and maintained effectively. Cold chain equipments such as ILR, deep freezer etc. were well maintained with functional temperature charts and updated records. There is a effective system in place for storage and transport of vaccines from the regional vaccine store to district vaccine store to ILR points to session sites.

xvii. Birth doses of OPV and Hep-B are being given to neonates before their discharge, BCG is mostly given DH and high case load CHCs to avoid wastage of vaccine.

xviii. Due list is being maintained by ASHAs and ANMs to track pregnant women for ANC and for immunization at VHNDs. ASHAs mobilizes the beneficiaries to the VHND sites. Incentives for ASHAs for full immunization were found to be up-to date. It was observed that ANMs had good knowledge and skill on immunization. Moreover, 4 key messages were given to all the mothers after immunization.

xix. It was found that none of MCP cards had mention of findings from antenatal and postnatal examination

10. Kerala

i. PPIUCD services were being provided at District as well as Taluk Hospital in kollam District.

ii. Availability of spacing methods commodities were found varying across health facilities.

iii. Out of the health facilities visited, only 1 AFHC at Victoria Hospital in kollam is operational four days in a week between 9 am-4 pm. There is a dedicated AH counsellor is in place. However, the footfall at the AFHCs was found to be very low. There was poor linkage with Mental Health Clinic, ICTC clinic, NCD clinic and de-addiction centres for providing comprehensive counselling services.

iv. Implementation of WIFS in the visited schools was found to be good. WIFS, IEC was displayed in the schools. JPHNs and ANMs are given responsibility of distributing IFA tablets to the adolescents in school on Monday of every week.

v. ANC services were available at all levels of the public health facilities with line listing of high risk pregnancies being done in most. However, ANC clinics include mainly TT immunization, distribution of IFA tablets and sporadic advice on rest and nutrition; with even basic diagnostic facilities for Hemoglobin estimation and urine albumin testing not available at the sub-centres.

vi. Most of the deliveries in the state are institutional with private sector contributing around three-fourths of the total. Of the total deliveries, around 51% are caesarean sections with elective CS, history of previous LSCS and not much effort in trial labor being the major reasons.

vii. AMTSL and plotting of partograph are not being conducted at majority of the delivery points.

viii. Maternal Death Audits are being conducted but only the direct medical causes of deaths are being recorded.

ix. A total of 14 SNCUs are available in Kerala with 239 beds, 49 NBSUs and 88 NBCC. Total 11321 newborns were admitted to SNCU last year in Kerala of which 46% are female. Main causes were Sepsis (7%), Jaundice (38%), and Respiratory Distress (20%).

x. Supervisory and mentoring visits are being conducted by SNCU staff to facilities functioning as delivery points (Taluk Hospitals). Majority cases in SNCU are inborn children. There are SNCUs run in private sector and out born children are not admitted to the public facility.

xi. The state has not yet stared the IFA supplements program in U-5 children and children of 5 age groups. The IFA supplements are nowhere available for the children.

xii. RBSK is being implemented in all the schools and dedicated RBSK nurses have been appointed. RBSK nurses were trained for 2 days in 2015 and 2016 and each nurse has been provided with a kit containing BP apparatus, stethoscope, thermometer, artery forceps (big& small), torch, measuring tape, Snellen's chart, small tray with lid, cutting scissors and necessary job aids.

xiii. The immunization schedule followed is different than national schedule. IThe state conducts multiple outreach sessions in a day with a team of JHPN, JHI and a doctor moving as a team from one session site to another on fixed day in a month. The incentives given to ASHA is Rs. 20/beneficiary mobilized instead of national norm of Rs. 150/session.

xiv. No standardized immunization stock register maintained at any health facility visited. Different vaccine stock records were being maintained at every health facility.

xv. MCP cards were out of stock for more than a year in Idukki district. However, in Kollam district MCP cards were available at all the facilities

visited. Moreover, the JPHNs in kollam were well aware about the immunization schedule and the logistic arrangement for immunization was also found to be in place.

xvi. The consolidated immunization coverage in both the districts for 2015-16 indicates TT coverage (both TT1 and TT2) to be nearly 20% lower than the institutional delivery.

xvii. Faulty implementation of open vial policy was observed in the field. There is a felt need for re-orientation, capacity building and regular monitoring of the service providers on implementation of open vial policy.

11. Madhya Pradesh

i. In Ratlam, daily on demand services are provided at District Hospital, 2 Civil Hospitals & 3 CHCs while fixed day services are also available at 5 more facilities.

ii. Inadequate knowledge and skill of staff nurses in IUCD insertion, limited follow up and counseling done, with beneficiaries reporting side effects, acute shortage of HR trained in Non-Scalpel Vasectomy, minilap, and LTT.

iii. There are 88 AFHCs in the RKSK districts of the state. The average client load of the AFHCs in visited district was found to be satisfactory. AH counsellors at the AFHC were providing counselling services to the visiting adolescent clients. However, few of the counsellors at AFHCs were not trained to provide counselling services.

iv. State reported 100% coverage of schools and AWCs under WIFS program in FY 2015-16. State reported 53% coverage of total beneficiaries of which 43% were in school and 29% were reported to be out of school. ERS is in place. Emergency response team has been formed and trained at the block level in all the districts.

v. For planning the facilities, maternal health norm for delivery points has been taken but its operationalization is not improving due to lack of adequate Human Resources.

vi. Reported number of maternal deaths in Ratlam (21) & Dindori (13)-low reporting of maternal death found in both the districts & all of these deaths were not reviewed by District MDR committee of CMO & DM. Maternal death review is limited to clinical cause and systemic gaps are not being identified.

vii. Well functional SNCUs, NBCC and NRCs are available but bed occupancy rate at Dindori SNCU was low. However, Ratlam SNCU was overloaded with close to 150%bed occupancy.

viii. Child death review has been done for few cases (only SNCU deaths),this is not systematically as per guidelines and findings are limited to clinical causes.

ix. The RBSK teams are incomplete in Dindori with a total of 7 instead of 14 teams in the district while in Ratlam training of RBSK team needs strengthening. The teams conducted screenings for 72,580 & 97,933 children in Dindori & Ratlam district respectively and have also been able to identify 9,296 & 8,721 children in Dindori & Ratlam district respectively for various interventions.

x. Mahila Swasthay Shivir (MSS) is functional but it is a duplication with NCD intiaitve and PMSMA.

xi. In both the visited districts, due lists were not available at most of the VHND sites visited. Mobilization of the beneficiaries at the VHND site was found to be weak.

xii. Involvement of ANMs for making micro-plans was sub-optimal, village wise RCH registers are yet to be used and active verification for missed out and left out cases is not being done. It was felt that the ANMs needs to be trained in identification, management & reporting of AEFI.

xiii. In Dindori, full immunization coverage has shown

significant decline in the district from 68.6% in 2012-13 (AHS 2012-13) to 49.4% in 2015-16 (NFHS 4), whereas in Ratlam, full immunization coverage declined to almost half the coverage from 85.2% in 2012-13 (AHS 2012-13) to 45.2% in 2015-16 (NFHS 4).

xiv. In the current year, six STFI were held of which only 1 DTFI was held in Dindori and none in Ratlam. Inadequate stock of IPV was seen at most of the cold chain points visited

12. Maharashtra

i. The scheme of Home delivery of contraceptives by ASHA is well implemented in Nashik District. OC pills, EC pills and Condoms are available in ASHA kits wherever present.

ii. Uptake of PPIUCD is relatively better in comparison to IUCD. NSV and PPIUCD trainings have been given to MOs. NSV is better received in the tribal blocks. Consent is obtained before procedures.

iii. At the health facilities visited in Nashik, essential commodities under RKSK programme such as Blue IFA (WIFS), Albendazole and Dicyclomine were available at both DH and CHC. Outreach activities are conducted to the schools/colleges by the counsellors.

iv. There was stock out reported by most of the districts in the state in last six months. State reported a total of 35% coverage of beneficiaries under WIFS program in FY 2015-16.In discussion with out-of-school adolescent's girls it was found that the uptake of IFA tablet and awareness regarding anaemia, its treatment, and dosage of IFA etc was good.

v. PMSMA is currently implemented in Maharashtra at PHCs, RH, SDH, GH and DH. The State was organizing the event at all levels including HSCs. Institutions having all facilities including ultrasound are being identified. The availability of USG services is a constraint in increasing the scope of facilities doing PMSMA.

vi. Comprehensive ANC services are in place. Every Monday/ Wednesday facility based ANC is ensured. In 2016-17 (till Sept) 38 % ANC registration has been made, out of which 97 % are registered before 12 weeks and 89 %are fully protected.

vii. Janani Suraksha Yojana awareness is good among the beneficiaries and they know financial benefits as well but it seems the scheme is underutilized in Nagpur District as utilization was 42% in 2015-16 and is at 28% this year so far.

viii. Beneficiaries are aware about JSSK benefits and no out of pocket payments were witnessed. The food was supported by Self Help Groups (SHGs) for mother during 03 days of hospital stay. Pick-up facility seems to be low (49%) wherein drop back is more than 90%.

ix. Services for Comprehensive Abortion care are available at the DH. All critical drugs including antibiotics, antihypertensive such as Inj. Labetalol and Inj. Magnesium Sulphate, Inj Oxytocin, Tab Misoprostol were found available at DH.

x. Though many of the evidence based practices such as use of Partograph, AMTSL, monitoring women for 2 hours in LR after delivery are being practiced; certain unwanted practices such as routine perineal shaving, enema and giving episiotomy to all primi gravidas were seen.

xi. MDR is well established in the State. 98 maternal deaths were reported in the district in 2015-16. Hemorrhage continues to be the leading cause accounting for 44% of maternal deaths. The other major direct causes include Sepsis accounting for 14% and PIH accounting for 13% of maternal deaths.

xii. At almost all facilities where MTP services are provided, it is provided on the condition that woman is willing to undergo sterilization or CuT insertion.

The numbers of MTP services in most facilities are low.

xiii. There are 2 SNCUs in the Nashik district and one in Nagpur. The DH (Nashik) has an 18 bed SNCU with bed occupancy of 250%. New SNCU has been sanctioned. The infrastructure of the SNCU at DH Nashik is good with central supply of oxygen and suction. SNCU has a dedicated and well trained staff. However, the staff was short as per the guidelines.

xiv. ANMs & ASHAs were not aware of the need for mobilizing infants discharged from NRC or SNCU for follow up visits. A structure needs to be put in place for follow up of these sick infants/ children.

xv. A Child Treatment Centre (CTC) is functioning at the RH Ramtek (Nagpur) and Trimbak FRU (Nashik). MAM and SAM children are admitted to the centre.

xvi. RBSK teams are present at the SDH and RH in Nashik district and two teams are present at SDH Ramtek (Nagpur) Teams include a male doctor, female doctor, pharmacist and an ANM. The teams have screened 31,508 students in 2015-16. 343 children were referred. The teams coordinate with the DEIC at Civil Hospital. 24 children have undergone cardiac surgery at private empanelled hospitals and super specialty hospital Nashik (Under RGJY).

xvii. In Nagpur- an app which sends update and reminder on immunization dates for mothers and children is being used by the ANMs for identifying and follow up of the cases. The app also lists the nearest govt. health institutions where day wise services are being given. It was informed that the app will soon be available on google play.

xviii. Immunization coverage of the state was reported to b 92% in 2015-16. Penta-valent vaccine reporting has been started in FY 2016-17. Birth dose vaccination is being provided at all the health facilities (cold chain points).

xix. ILRs and DFs were found functional though stem thermometer for manual temperature reading needs special attention at a few facilities visited.

xx. Poor management of vaccine stock observed at all the cold chain points. New standardized vaccine registers already launched by GoI needs to implemented in the state.

xxi. New job aids related to immunization program for ease of Cold chain handlers as designed by GoI was seen at the health facilities visited

13. Nagaland

i. Nagaland has an unmet need of 41.6% (DLHS 4). All the beneficiaries interviewed in FGD and village visits denied of any FP counselling.

ii. IUCD is one of the preferred spacing method but 50 % the IUCD were removed at DH without any obvious cause. There is a huge potential for IUCD insertion services however the performance has been dismal. PPIUCD is yet to pick up in the Nagaland.

iii. AFHCs are at the DH and CHC level. Average client load at the clinics was reported to be very low. Training of the service providers at the AFHC (MO, Counsellor and ANM) has not been completed as yet. There is no dedicated AH counsellor at the clinic, ICTC/ STI/RMNCH+A counsellors provide counselling to visiting adolescent clients. Tools like weighing machine, BMI chart, height chart and IEC material on RKSK were not available at the visited AFHCs.

iv. IFA tablet stock was procured at the state in January 2016 prior to that there has been stock out of IFA tablets from June-December 2015. Despite state and district level convergence meetings, the coverage of beneficiaries under WIFS was reported to be very low (1.1% in FY 2015-16).

v. Owing to difficult terrain, poor referral transport mechanism, low awareness of various entitlements (JSSK, JSY) and unique cultural preferences the percentage of Home deliveries is very high (66.1% as per DLHS-IV). Institutional deliveries have also fallen sharply from 47.0% in DLHS-III (2007-08) to over 18% as per RSOC 2013-14.

vi. Pradhan Mantri Surakshit Matritva Abhiyan has not been initiated in both the districts. Most of the payments under JSY to mother as well as ASHA are paid through cash. Under JSSK out of pocket expenditure for pregnant women and sick new-borns were observed.

vii. Of the total number of SNs/ ANMs interacted, more than 50% of the staff were not trained in key essential trainings of SBA, NSSK, RKSK, and PPIUCD.

viii. The districts in the current year have reported no maternal deaths. However, there are high risk pregnancies happening and in current scenario these are not being identified and captured.

ix. NBCCs were available at most of the delivery points. However, they were not completely equipped in most of the functional delivery points. None of the high priority districts have a functional SNCU in place. A NBSU was observed to be functional in district Mon. However, there was no NBSU functional in Tuensang district.

x. Home-based new-born care programme is not functional in both the districts. ASHAs did not have the HBNC kits with them and DCM & BCM aren't aware about the programme.

xi. In RBSK, Screening & follow up is not effectively implemented. Screening of 0-6-year-old children is just 4% and 6-18 age group enrolled in the Govt./Govt. aided schools is 41%.

xii. Micro plans were not updated owing to hard to access areas. Most of the immunization sessions were at SCs and outreach sessions conducted are very less. It was reported that Mon district had recent outbreak of measles due to limited coverage and poor micro planning. There was minimal awareness on AEFI on the field.

xiii. Mission Indradhanush identified sites are not included in the routine immunization micro plan as yet. EVIN has been recently initiated in the state.

xiv. Alternate vaccine delivery mechanism is not present. ANMs visit the district vaccine store a day prior to immunization session and give the vaccines back after a day of session in most of the far of sub-centres.

xv. The terrain of the district makes it difficult for most of the sub centers to collect the vaccines from the block HQ

14. Tamil Nadu

i. The Interval IUD insertion being done and fixed day sterilization services at L2 and L3 are being conducted on Friday with records well maintained and informed consent being taken in Tirunelveli district.

ii. In CHC Ernapuram, only female sterilization is done twice a week and since there is no trained manpower, PPIUCD is not implemented. The PHCs also conducted PPIUCD. None of the HSCs except for HSC Perumapatti are providing IUCD insertion facilities, though VHNs (ANMs) are trained in IUCD insertion and the HSCs have IUCD stock.

iii. The average client load at the visited AFHCs was found to be satisfactory. The AFHC had a dedicated space along with trained HR and available commodities like sanitary napkins, blue IFA, albendazole, condoms etc available in adequate quantity.

iv. None of the districts reported stock out in last six months. All the govt. and govt.

aided schools and AWWs are covered under WIFS scheme. The state reported 83% coverage of all the beneficiaries under WIFS scheme. Emergency response system has been established at the state, district and block level.

v. The maternal mortality ratio of Tamil Nadu is far below the national average and SRS too shows a decline in the trend. Similarly, other key maternal health indicators such as ANC and institutional deliveries are 71% (DLHS-4) and 99% respectively. However, quality of care still needs to be focused upon, which is very appreciable. However, there is a need to focus on the quality of care.

vi. PMSMA has been implemented from June 2016 in Tamil Nadu. Beneficiaries are aware of the scheme and there is optimal utilization of the services. All the ANC services: Haemoglobin, urine and blood sugar are checked, Ultrasonography done, IFA and calcium supplement given and Inj TT including USG are being provided during PMSMA day.

vii. Interaction with the mothers in the post natal ward of the health facilities revealed that the mothers get the JSY payment through cheque All the JSY payments are now being done through DBT in the state.

viii. JSSK has been implemented and providing free services such as drugs and consumable, blood, investigations, diet and free referral to facility in both the district.

ix. Identification and line listing of all High Risk Pregnancies (HRPs) are available at all levels of care. Pregnant women identified with severe anaemia are well managed and Iron sucrose injections and blood transfusion are being provided as per the anaemia management protocols.

x. It was observed that across the delivery point facilities, partographs were available and were attached to the case/discharge sheets and the SN posted in the labour room had sound knowledge.

xi. However, it was found that few staff nurses working in facilities under Director Medical services (DMS) and medical college are not trained in SBA and NSSK.

xii. The state has robust maternal death review mechanism. The MDR is carried out at 4 levels- Community level verbal autopsy by VHNs, Institutional level, District Collector level and monthly at the State level by video conferencing.

xiii. The status of SNCUs in both the districts varies as far as the service delivery is concerned. In case of Namakkal district, there are well established SNCUs as per the national guidelines and DH Namakkal has a state of art SNCU.

xiv. RBSK is effectively implemented in the state with adequate RBSK mobile health teams recruited and trained. Each team consisted of Medical Officer, Staff Nurse or CHN and pharmacist and were trained for five days. The planning for screening visits of RBSK teams is in place with effective coordination with nodal officers of education and WCD department.

xv. STFI and DTFI have been well established in the state. Last DTFI meeting in Namakkal was held in September 2015.

xvi. All vaccines were available at the facilities and birth doses of OPV, BCG and zero dose of Hep-B were given at all the facilities visited, except for Nanguneric SDH, where cases were referred back to the SC.

xvii. Cold chain was well maintained at all the levels with cold chain technicians in place. Protocols/Job aids on cold chain management were well displayed at all the cold chain points.

xviii. Open vial policy is being followed. However, the reconstituted vial, open vials, unused vials and used diluent vials are returned back to the cold chain points in the

same packet as it is being maintained at the ILRs.

xix. Knowledge regarding immunization schedule, newer vaccines and vaccination schedule was poor amongst the VHNs.

xx. Micro plan along with due lists are available with VHNs. MCP cards are available with immunization counter foils and immunization status is well recorded in the MCP cards. The counterfoils were found to be updated and maintained at session sites in the tickler bag.

xxi. AEFI is reported as per the protocol. Alternate vaccine delivery is not available except for the UPHCs in Namakkal district

15. Tripura

i. Availability of contraceptives in new packaging was variable. Availability of ECPs and pregnancy testing kits found variable across facilities. There was, in general, a shortage of RMNCH counselors, even in high case load facilities.

ii. OCP is the preferred choice of contraceptive. Very few IUCD insertions and even fewer PPIUCD insertions are done. At certain places, no IUCD insertion was noted even with availability of trained providers. The uptake of male oriented contraceptives was found to be low.

iii. The AFHCs are established from DH till PHC level. Average client load at all the visited AFHCs was found to be very low. The AH counsellors placed at the AFHCs are either not in place or not trained. There was a poor display of IEC material at the adolescent friendly health clinics. Registers are well maintained by the counsellors and outreach visits are made to schools and VHNDs.

iv. Procurement of IFA tablets under WIFS was done in September 2015, procurement for FY 2015-16 is in process. IFA tablets are being provided weekly to the adolescents in school. However, implementation of WIFS through AWCs was found to be weak.Emergency response team has been formed in all the districts.

v. Antenatal care (ANC) services are being provided, and the figures for number of women receiving >3 antenatal care checkup for the state have increased, however, quality of ANC services was found to be a concern as the complete set of services/lab tests were not provided.

vi. There is high number of institutional deliveries in the state. However, in district Gomati, certain pockets were found where home delivery is high.

vii. Home based distribution of misoprostol is not carried out in the state, nonetheless, implementation of home based distribution of misoprostol in pockets with high home deliveries may be considered.

viii. JSSK: Free diet during stay is available at the facilities visited. Free diagnostics are also available; however, complete set of diagnostic services is not available, eg. USG facility is available only at the District Hospital.

ix. Implementation of PMSMA is variable and yet to be conducted in full mode. Other new initiatives such as advance distribution of misoprostol, calcium & folic acid supplementation of pregnant women, deworming during pregnancy have not been initiated yet.

x. Maternal Death Review: Constitution and functioning of District MDR Committee was found variable. Only facility based maternal death review is being done.

xi. There is significant unmet need for Comprehensive Abortion Care services. Currently CAC services available only at district hospital. The establishment of MCH wing at Gomatineeds to be expedited.

xii. At present three SNCUs are functioning at State,

namely, IGM hospital, GBP hospital and TMC. There was no SNCU at either of the districts visited, however, it is sanctioned and expected to be operationalized soon at both the districts.

xiii. Although HBNC is being practiced, most ASHAs need refresher training to improve quality of counseling skills, identification of danger signs and inter personal communication on newborn care.

xiv. Infant death reviews are not conducted as per protocol. There is need to improve documentation and processes for the same.

xv. Two STFI meetings have been conducted since January 2016, which included ToR on Mission Indradhanush and tOPV to bOPV switch.

xvi. The Multi Purpose Supervisor (MPS) handles the cold chain points. There is a need to train the cold chain handlers (MPS, ANM etc.) including cold chain technicians and the medical officers on the respective modules.

xvii. It was observed that temperature monitoring was not being done on holidays even at 24X7 facilities, or was filled in advance in some cases. Availability of standardized vaccine stock and vaccine distribution registers was not uniform.

xviii. Alternate vaccine delivery mechanism not practiced in either district. Birth dose of Hep B and OPV zero doses are not provided for institutional deliveries.

xix. At the facilities in district Dhalai that Hep B birth dose was administered as per the admission/ward register but was not reflected in HMIS data, indicating the need to focus on data quality.

16. Uttar Pradesh

i. Home Delivery of Contraceptives was well implemented in the district. ASHA supplied with OCP, ECP, condoms and pregnancy testing kits.

ii. Interval IUCD service uptake is very poor in the district. Counselling over family planning method found to be poor during ANC and PNC periods. Availability of FP commodities sufficient at all level of facilities. ANM/ SN demonstrated skills in insertion of IUCD at all facility.

iii. The AFHCs are functional at the level of DH and CHCs in the visited districts. There is a dedicated AH counsellor posted at the AFHCs in the DH. The client registration record showed that most of the adolescents visiting the AFHC are married. The service delivery register at the clinic showed that most of the adolescent visited the clinic with complaints related to skin and learning problems.

iv. The state reported 16% total coverage of beneficiaries of which 22% was in school and 12 % were out of school. Procurement of IFA tablets is done at the district level according to rate contract.

v. State has MHS program under state budget in the name of “Kishori Suraksha Yojana”. Wherein free distribution of sanitary napkins are being done in schools for adolescent girls in 50 districts.

vi. MCP cards not completely filled, it mainly focuses on key things like BP, Hb, TT, Weight, and IFA. Identification of High risk pregnancies is very low, Line listing of high risk pregnant not maintained. The record maintenance quality is poor at the level of facility or with ANM at Firozabad.

vii. District data reveal that 68% of the deliveries are conducted at institutional level and 32% are home delivery. Most of the home deliveries go unattended as district doesn’t have any specific strategy for it.

viii. Payments under JSY are happening through Direct Benefit Transfer (DBT). There is delay in the payment as some of the beneficiaries still do not have bank account.

ix. The utilization of transport services was more in the rural areas and where ASHAs are active. Majority of the normal deliveries have stayed less than 24 hours regardless of being proper counseling by the health staff and provision of JSSK services.

x. Comprehensive abortion Care provided at District hospital, Both MVA & EVA methods used for abortion. Firozabad reported good number (2050) of spontaneous abortions while only 303 reported from Gonda.

xi. 88 Maternal deaths (25% of target) have been reported from April to October 16. The major reasons for the deaths reported are Hemorrhage (49%) and Sepsis (15%). The district has a mechanism for MDR. 78/88 deaths have been reviewed in the district, 6 deaths reviewed by District Magistrate.

xii. Home Based New Born Care kit available with all ASHA met. Their knowledge regarding the danger signs identification in new-born and mothers was good.

xiii. The Mortality profile showed 27% mortality reported in SNCU GONDA while 7% reported from SNCU Firozabad.

xiv. National Iron Plus Initiative is not implemented in the districts, Iron Syrup not available with ASHA/ beneficiaries, 6-10 age group is missed out in the program.

xv. No referrals from Field level (ANM/ASHA/AWW), SAM cases identified in the OPD of District Hospitals are only admitted in the NRC. Admission criteria not followed in many cases as NRC meant for sick SAM children. Basic equipment not in place (weighing Machine). Low cure rate, investigation and clinical supervision followed after admission for sick children

xvi. RBSK initiated in both the districts. Screening at School and AWC is going on. Most of the RBSK teams are not complete.The district does not have DEICs.Around 47% schools and AWC have been visited by RBSK teams and 27% children have been screened against target till October 2016.

xvii. More than 50% of the sub-centers in Gonda do not have an ANM at the SC which is adversely affecting the health programs under NHM.

xviii. Micro plan for immunization needs to be updated and should also incorporate plan to cover the sub-centers with no ANMs in place.

xix. EVIN is being extensively used and there is no mismatch in stock reported.

xx. Cold chain is maintained at all the levels and all vaccines were found to be available at cold chain points with functional temperature charts.

xxi. Though birth dose vaccination is being given every day, there is no SOPs to ensure every child is vaccinated before discharge as the vaccination is at fix time once a day whereas post natal stay is only for about 6 hours.

TOR 3 | COMMUNICABLE Disease Control Program

OBJECTIVES

- To review the extent of implementation of specific public health strategies under each Communicable Disease Control programmes, illness management and data usage.
- To assess the integration of disease control programmes with RMNCH+A initiatives, adherence to existing referral mechanisms and treatment protocol etc.

National Overview

Communicable diseases continue to be a major public health problem in India. Malaria situation has stabilized to around 1.5 million cases per year in the past few years. However, a consistent decline in the incidence has been observed and in the last 10 years'and total malaria cases declined by 42%, from 1.92 million in 2004 to 1.1 million in 2014, combined with a 40.8% decline in malaria related deaths. Similar declining trends have been observed in Kala Azar cases (from 44,533 in 2007 to 9241 cases in 2014).

Lymphatic Filariasis (LF) is endemic in 255 districts of 15 States and 5 UTs of India, with about 650 million population being at-risk. The progress of Elimination of LF (ELF) programme is reflected in the increase of MDA coverage from 72% in 2004 to 88% in 2012 and reduction of overall Microfilaria (Mf) rate from 1.24% in 2004 to 0.44% in 2012.

Chikungunya cases have been reported from 22 States and 3 UT's. In the year 2015, a total 27,553 clinically suspected case of Chikungunya were reported.

The incidence of Japanese Encephalitis(JE) is usuallynot a complete indication of at-risk population in JE endemic areas.This is because of, a) unapparent infections, which tend to outnumber the apparent infections and b) due to the lifelong immunity, which develops despite unapparent infection. The ratio of overt disease to unapparent infection varies from 1:250 to 1:1000. Thus the cases of JE represent tip of the iceberg compared to the large number of unapparent infections. JE continues to be a challenge for the country and the high endemic States are Andhra Pradesh (12 Districts), Assam (16 Districts), Bihar (24 Districts), Tamil Nadu (13 Districts), Uttar Pradesh (34 Districts) and west Bengal (10 Districts).

Revised National Tuberculosis Control Programme (RNTCP) has been often labelled as successful intervention. For instance, there has been a 50% reduction in TB mortality rate in 2013 (19) as compared to 1990 (38). Similarly, there has been 55% reduction in TB prevalence (211 per lakh population) rate by 2013 as compared to 1990 level. In absolute numbers, prevalence has reduced from 40 lakhs to 26 lakhs annually. The incidence per lakh population has reduced from 216 in year 1990 to 171 in 2013. However, the challenges of MDR and XDR TB are emerging as serious threats for the country. In all States, supplies of drugs

have been ensured to deal with resistant tuberculosis cases and facility of Cartridge Based Nucleic Acid Amplification Test (CBNAAT) exists but its use varies in different States and needs to be improved.

In Leprosy, the country has achieved the goal of elimination of leprosy (less than 1 case per 10,000 population) as a public health problem. Nonetheless, the capacities of first-line workers needs to be sustained, particularlyin high endemic districts (with new case detection rate >10/100,000 population) of Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Uttar Pradesh, Uttrakhand, and West Bengal.

Key Findings

1. Integrated Disease Surveillance Program

Establishment and functioning of Surveillance units have been observed across all the 16 CRM States. S, P and L form reporting is being done in all States but it needs to be strengthened in Bihar and Gujarat. Inadequate IT infrastructure was reported from Arunachal Pradesh, Nagaland and Tripura. The district level priority labs and state level public health laboratories need to be strengthened in Bihar, Himachal and Jammu & Kashmir. Inadequate human resources under IDSP were observed in Delhi, Himachal Pradesh, Madhya Pradesh, Maharashtra, Nagaland, and Tripura. Further, the capacities of the staff need to be strengthened in Bihar, Gujarat, Madhya Pradesh, and Nagaland. Regular analysis of HMIS data (at district level) was observed in States other than Himachal Pradesh, Jharkhand, Madhya Pradesh, Nagaland and Tripura. Reporting from private health facilities on notifiable diseases was observed to be an issue in the States of Andhra Pradesh, Arunachal Pradesh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala and Uttar Pradesh. Lack of coordination with IDSP and other stakeholders was observed in Arunachal Pradesh, Delhi, Himachal Pradesh, Jharkhand and Uttar Pradesh.

2. National Vector Borne Disease Control Program (NVBDCP)

Malaria

Malaria shows increasing trends in Himachal Pradesh and Maharashtra, while declining trend of malaria cases were reported from Andhra Pradesh, Arunachal Pradesh, Bihar, Chandigarh, Madhya Pradesh, Nagaland, Tripura and Tamil Nadu. Increasing trends of malaria in Maharashtra is a cause of concern and state is considering to include malaria as a notifiable disease. RDT kits for malaria were available in Madhya Pradesh and Maharashtra at all level and ASHAs were observed to be trained to use these kits too. However, there was a lack of these kits in Arunachal Pradesh and Jharkhand (particularly at PHC and SHC level), Delhi (at CHC level) and Tripura (at CHC level), Gujarat and Jammu & Kashmir. LLIN distribution and use was satisfactory in Arunachal Pradesh, Nagaland and Tripura. However, in Jharkhand the LLINs are yet to be distributed in the community. ASHAs and MPWs staff were trained and performed well in terms of referring suspected fever cases and using RDT kits at field level in Arunachal Pradesh, Tamil Nadu

and Madhya Pradesh whereas relatively limited involvement of these front line workers was observed in Chandigarh, Himachal Pradesh, Maharashtra and Tripura.

Japanese Encephalitis

Increased incidence of JE cases was observed in Tripura and Andhra Pradesh. Mortality due to JE was reported from Tripura and Uttar Pradesh. Coverage of JE vaccination was observed to be good in Tamil Nadu. However, coverage of JE vaccine is poor in Bihar and Uttar Pradesh.

Chikungunya

Chikungunya shows increasing trends in Andhra Pradesh, Maharashtra, Tripura and Uttar Pradesh and showed decreasing trends in Tamil Nadu. No case of chikungunya was reported from Bihar and Nagaland this year. Diagnostic services for chikungunya were observed to be made available in public institutions in Chandigarh, Delhi and Maharashtra at district level health facilities. However, availability of the diagnostic tests was lacking in Uttar Pradesh.

Dengue

Declining trends in Dengue was observed in Arunachal Pradesh, Himachal Pradesh and Tamil Nadu, while increasing trends observed in Andhra Pradesh, Chandigarh, Delhi, Maharashtra, Tripura and Uttar Pradesh. Increased incidences of dengue were also reported in Kerala, Delhi and Nagaland. Increasing trend in Maharashtra is a cause of concern as the mortality due to dengue is also high in this state.

Kala Azar

Declining trends of Kala Azar with zero mortality was observed in Bihar and Jharkhand.

Lymphatic Filariasis

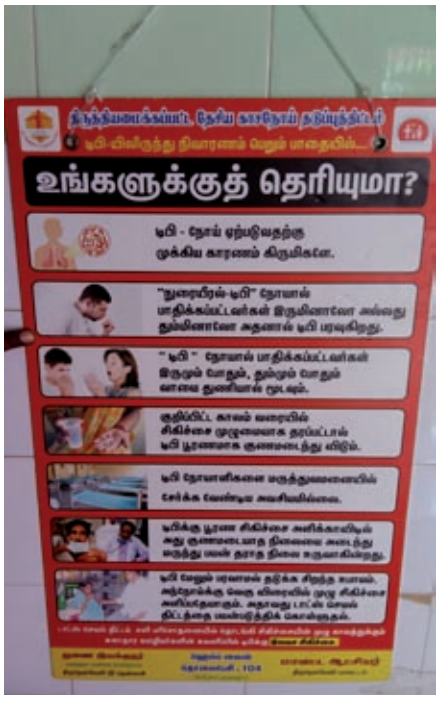
Declining trends of Lymphatic Filariasis was observed in Andhra Pradesh, Maharashtra and Jharkhand. Endemic districts (for LF) did not report any new case in Uttar Pradesh and Bihar. Transmission Assessment survey (TAS) was carried out in Andhra Pradesh and Tamil Nadu. Special night clinics under Filaria control programme in high risk areas were observed to be functional only in Maharashtra.

IEC/BCC

IEC/BCC activities were not satisfactory in Arunachal Pradesh and Nagaland. IEC/BCC using hoardings and posters were visible in all visited facilities of Chandigarh, Himachal Pradesh, Jharkhand and Tamil Nadu but not so much in outreach sites or beyond health facilities. However, in Madhya Pradesh and Maharashtra IEC and awareness activities were taking place at facilities as well as at community level (using pamphlets, banners, posters, hand bills and through street play etc.).

3. Revised National Tuberculosis Control Program (RNTCP)

Although RNTCP programme across allStates is being implemented well, however, the increasing burden of MDR and XDR cases is an area of concern. The Suspects examined per lakh population/quarter is ranging from 106 (Bihar) to 303 (Himachal Pradesh). Almost all the States visited during 10 CRM have achieved the case detection rate of 80 per lakh population per yearand Sputum Conversion Rate after three month was observed to be in the range of 80 to 90% in all States. However, the States of Andhra Pradesh, Bihar, Chhattisgarh, Haryana, Jammu &Kashmir, Jharkhand, Madhya Pradesh, Maharashtra, Tamil Nadu, and Uttar Pradesh have not achieved the cure rate up to 90%. The State reports reveal that 63% of public institutions



now have co-location of TB HIV facilities and all States have the facility of Cartridge Based Nucleic Acid Amplification Test (CBNAAT) available. However, wide variations were observed amongst States in terms of utilization of the services. For instance, use of CBNAAT is ranging from 15 (Jharkhand) to 200 (Himachal Pradesh) cases per month. Shortage of human resource has been observed at the State level as well as at district level in the States of Andhra Pradesh, Delhi, Himachal Pradesh, Jammu &Kashmir and Jharkhand. Maximum shortfall was in Himachal Pradesh (60% at state level and 25% at district level). Delay in payment of salary of staff was observed in Arunachal Pradesh and Delhi; while Bihar has reported a backlog of honorarium payments to ASHAs. Andhra Pradesh, Arunachal Pradesh, Bihar, Chandigarh, Delhi, Madhya Pradesh, and Nagaland reported regular entry of data in NIKSHAY system. Involvement of ASHA was seen in all the States/UT except Delhi, Arunachal Pradesh and Tamil Nadu. None of the States have reported unavailability of anti-TB drugs but regular supplies of drugs need to be further strengthened. For instance, a shortage of Ethambutol was reported from the State of Arunachal Pradesh which is hampering the progress.

4. National Leprosy Elimination Program

Annual Prevalence Rate (2015-16) have come down in Andhra Pradesh, Bihar (1.12), Himachal Pradesh (0.21), Madhya Pradesh (<1 for previous 5 years), Tripura (0.2) and Uttar Pradesh (0.35); while it has increased in Arunachal Pradesh (0.8). Though Tamil Nadu has achieved the goal of elimination of leprosy in 2005, increasing trends of notification of child cases of leprosy was observed and is a cause of concern. Sub-optimal active surveillance is reported from Kerala, Tamil Nadu while decreased activities in surveillance of leprosy is reported from Uttar Pradesh (a high endemic state). Adequate drugs and diagnostic services were reported from all States. However, almost all States have reportedshortages of manpower (SLOs, DLOs, Physiotherapists, Dressers, consultants, non-medical attendants, etc.). Most States and UTs have also reported that rehabilitation faces constraints due to unavailability of physiotherapy equipment.

Recommendations

1. All States reporting increased incidence and case load of malaria should scale up the activities under National Malaria Elimination Framework. Capacity building of first-line staff under various programs, particularly leprosy, tuberculosis and malaria must also be prioritized.

2. States must use the opportunities presented by initiatives such as Swacch Bharat Mission to streamline vector control measures and strengthen collaborations with municipalities and other local self-government bodies.

3. Adequate manpower under NLEP need to be ensured for disability prevention and medical rehabilitation.

4. There is also a need to utilize the platform of VHND through ANM/MPHW/ASHA for identification and referral of suspects as well as early case diagnosis.

5. Diagnosis facilities for the various spectrum of vector borne diseases must be made available at select sub-district facilities, particularly in high endemic areas.

6. Recommendations of previous CRM vis a vis strengthening of entomological activities, death audits, recruiting adequate human resources need to be implemented.

State Findings

1. Andhra Pradesh

i. State has launched special campaign "Domalpai Dandayatra" to create awareness in the community. Every Friday is observed as 'Dry Day' for Vector control and every Saturday as 'Sanitation Day'. States has formulated a law **'Mosquito breeding prevention act'** which has got cabinet approval, for control and monitor mosquito breeding sites.

ii. Transmission assessment survey (TAS) conducted in Guntur and West Godavari. MDA is planned in Vizianagaram district in this year. The sentinel centers for JE at KGH/AMC-Vishakhapatnam, GGH/GMC-Guntur and GGH/KMC-Kurnool are functioning.

iii. All 13 districts in the state are reporting in the IDSP portal. The reporting of S Form is 98%, P form is 99 % and L forms are 98% during 2015.

iv. 5 leprosy endemic districts in the state are identified based on ANCDR more than 10 per lakh population as on March 2016.

v. E-Smart is an IT enabled state innovation for minimizing the diagnostic and treatment delay of Drug Resistant TB patients, tracking and improving the treatment outcomes. E-Lab is another state initiated software application to identify and track missing diagnosed TB cases from the public notification system. Both these are successfully piloted in 6 districts and will be scaled up to whole state from 1st Dec 2016

2. Arunachal Pradesh

i. The yearly positive cases of malaria have decreased in Upper Siang from 271 cases in 2014 to 74 cases in 2015 and in 2016 till date only 40 cases have been reported.

ii. For diagnosis of malaria test like RDT is free but in CHC Mariyang, it was found that Rupees 150 is taken as user fee for RMT which is against the guidelines.

iii. Action plan for dengue prevention for year 2016 was available at East-Siang district, with well documented procedure to contain the likely outbreak in concentrated urban areas like Pasigaht Township and its vicinity areas.

iv. In spite of poor awareness of 22 notifiable diseases to district IDSP cell, District is reported to have weekly reporting status of District Surveillance Unit (DSU) is around 86% (for P-form), 86% (for L-Form) and 84% (for S-Form) at East Siang whereas in Upper Siang weekly reporting status of is around 80% (For P-form), 65% (For L-Form) and 45% (For S-Form).

v. Shortage of essential antibiotics like Ethambutol etc. was reported at district TB hospital- Pasigaht forcing patients to buy it from the market. X-ray unit at district TB hospital East Siang was non-functional, Microscopy centres (Ruksin, Boleng, Jengging & Mariyang) are under-utilized. Since cases were referred directly to District TB hospital- Pasigaht and TB hospital-Yingkiong.

vi. Under NLEP, no data was available on number of Reconstructive Surgeries (RCS) done in the state.

3. Bihar

i. Kala Azar trend is steeply declining. No deaths reported in 2016. It receives optimal political and administrative support. Good support by CARE India for micro-planning of IRS activities, community meetings, active case detection in schools and new concept in KA IEC.

ii. Surveillance is grossly compromised. Human resource issues, cross cutting many national programs adversely affects surveillance also. ANM's and ASHA's role in surveillance of communicable diseases is neither visible nor feasible.

iii. Under RNTCP, DOT providers are mostly ASHAs, HIV screening of TB cases is complete in District TB Centre. Contact tracing and active case search is yet to happen and Private TB notification is yet to begin.

iv. Under NLEP, case finding efforts are below par, there is high default rate from treatment and patient retrieval system is inefficient, documentation is poor and there is no system for digitization of data and there is lack of monitoring and supervision at district and peripheral level.

4. Chandigarh

i. The UT has well established Dengue surveillance system. During 2016, 776 Dengue positive cases were reported. Approx. 3/4th cases are from neighbouring states of Punjab and Haryana.

ii. During 2016, the IDSP UT reported an outbreak of Cholera (23rd week onwards), Dengue (37th week) and Chikungunya (38th week) in 2016.

iii. RNTCP is being implemented in Chandigarh since Jan 2002. Chandigarh has achieved the National level programme indicators of 90% total case notification rate and 90% success rate among new TB cases. The UT received first prize for best performance in RNTCP in Year 2016.

iv. Leprosy cases have increased in 2016, most of the Leprosy cases diagnosed and put on treatment are from other states who are coming for treatment to Chandigarh. As per the data from UT in Yr 2015 -16, out of 136 new cases detected, only 22 cases were from Chandigarh.

5. Delhi

i. Preventive activities for vector born diseases are carried out by Delhi Municipal corporations (DMCs). Coordination and monitoring are the weakest components. State NVBDCP has only the Programme officer, no manpower or support staff.

ii. Data Discrepancy seen; as per state VBDCP 3650 cases of dengue but as per IDSP 8737 cases were reported for 2016. Similarly for Chikungunya as per state VBDCP 8720 cases but as per IDSP 16805.

iii. GTB hospital is identified sentinel surveillance Hospital for Dengue and Chikungunya but has not received any contingency grant (NVBDCP fund) till date.

iv. Delhi is one of the six Bedaquiline sites in the country providing extended DST to all MDR patients. RNTCP facility in GTB, Swami Dayanand Hospital and Kantinagar need maintenance.

v. NLEP being managed by the Skin departments of CHC and super-specialty hospitals and no reconstructive surgeries are conducting in public facilities but cases were referred to a Missionary Hospital in Shadhra for RCS/ Tendon Transfer.

6. Gujarat

i. Navsari is an endemic district for malaria, nutrition support is being provided to all TB Patients and school kits for the children of these TB patients with the support of various NGOs like Leprosy Nivaran Mandal, Lions club, Adivasi Seva Group Vansda, and Nithish Mehta & Family which resulted in improved treatment compliance.

ii. Monteux test made compulsory in CMTC (Child Malnutrition Treatment Center) since 4 months by a joint directive given by Additional Director FW and Additional Director PH as an innovative in the state which helps in early detection of child TB.

iii. Government of Gujarat through social welfare department is providing 500 rupees per month to all TB patients of SC, ST, OBC and EBC communities for entire course of treatment.

7. Himachal Pradesh

i. Number of malaria cases in the state has gone up from 49 in 2015 to 87 in 2016 and dengue cases has gone down no deaths have been reported.

ii. Active Inter sectoral coordination with all stakeholders is required for effective roll out of National Framework for Malaria Elimination.

iii. Mandi district had reported 6 outbreaks in the last 6 months (April–Sept'16) of Measles, Diarrhoea and gastroenteritis with only 1 death. Solan District has reported one Outbreak of

Viral Hepatitis with 780 cases affected with date of onset on 14/01/2016 and one outbreak of Gastroenteritis in May 2016 with 19 affected.

iv. The state is yet to implement the revised pay structure under RNTCP as pay revision proposed by CTB Division is higher than other staff to maintain parity in salaries among all staff irrespective of the Programmes they serve.

v. Though initial registration of patients in NIKSHAY has been 100%, timely and up-to-date registration of TB-HIV status, follow-up and outcome reports is a challenge in the districts.

vi. Under NLEP, Knowledge on NLEP of front-line health workers including ASHAs needs to be updated; no reconstructive surgeries have taken place in the state till date.

8. Jammu and Kashmir

i. District Malaria Officers & Malaria Inspectors positions were vacant in 4 New Districts of Jammu Division. Transportation facility for Entomological team for entomological studies is not available in Jammu Division.

ii. At State Level, data was being compiled weekly and analyzed regularly. A total of 1533 reporting units are functional in the State (80% P form, 71.3% L form & 74.6% S form).

iii. ALL the Laboratory Technicians (LT) of DMCs visited were trained in RNTCP, but programme is functional vertical and not fully merged with NHM. State TB Control Society is functional parallel with State Health Society at State level and District TB Control Societies are functional parallel with District Health Societies at District level.

iv. District Anantnag is a non-endemic district, during last 5 years. 16 cases of leprosy were detected in the district and most of the cases were from outside States. The PR trend in the last 5 years is 0.55/10,000 population. At present 5 cases of leprosy patients have been detected and are under treatment at the centre under MB during 2016-17.

9. Jharkhand

i. State is reporting zero malaria death, there is need for active death surveillance in the community taking services from other sectors, Adequate testing kits (RDT Kits) and Anti-malarial drugs were available at all levels

ii. Four districts bordering Bihar (Godda, Pakur, Dumka & Sahibganj) are the notified endemic areas of Kala Azar in Jharkhand. The districts have shown declining trend of Kala Azar with zero mortality in recent years. There was poor visibility of IEC materials in the community for all VBDs.

iii. Percentage of TB patients with known HIV status Garhwa (30%) & Godda (46%) which is below state average of 70%. The FICTC-DMC collocation is 45% in Godda & 80% in Garwha.

iv. Only 60% of the presumptive MDR patients received DST during 2016 in Godda district, which is below state average of 77%. Expected is 100%.

10. Kerala

i. Majority of malaria and dengue cases are reported from the migrant population or out of state travellers. Migrant population is mapped at PHI level and detailed records are kept at PHI level for routine screening. Current mechanism requires a complementary support of inter-area feedback mechanism for frequently moving migrants. Passive surveillance of fever cases are recorded and if found positive it is been reported to District Medical Office.

ii. District level monitoring unit is working as nodal point of coordination while inter institute co-ordination is not well established at sub-district level.

iii. All health facilities in public sector are reporting disease

however; Urban Health Center is yet to be enrolled as reporting unit. State has initiated process for the enrollment. Very few cases are being reported from the private sector health institutions to IDSP may be due to limited numbers of private facilities are reporting to IDSP.

iv. Under NLEP, DPMR Activities are done including– POD Camps, MCR sleepers, Self-Care Kit, Supportive splint. No specific efforts being carried out for active search of the cases and knowledge gap was observed in field staff for identification of leprosy suspects. Current patients on MDT treatment being provided medicines through ASHA. Screening Camps are been organized in School, Migrant population areas and Tribal areas.

v. Under RNTCP, state has implemented pre-elimination strategies to reach targets set by SDGs which includes focus intervention for high risk population (migrants, tribal, Active case screening, long term follow ups, contact screening) enhance supervision and monitoring.

vi. Significant involvement has been observed with the private sector and other public sectors (ESIS and Railway) in terms of expanding services to private sector patient and TB notification from private sector, however few districts are still in primitive state of private engagement.

11. Madhya Pradesh

i. As per State report, Malaria cases have declined by 26% during year 2016 compared with year 2015. There are many CHCs, SCs and many villages which fall in the category-3 (ARI classification).

ii. There is a good well-coordinated effort by district for inter departmental involvement and convergence. Few to mention are ICDS, NRLM, PHED, Tribal and Forest department. The frontline functionaries of these departments are trained and provided with testing kits and follow ups.

iii. For primitive tribes District Authorities utilizing the participation of religious leaders to encourage and motivate the beneficiaries for complete treatment and taking medicines.

iv. Many block level positions are vacant and critical positions like surveillance inspector and Malaria supervisor are not filled. In Dindori, there is no dedicated district level HR for IDSP. Epidemiologist not in place at the district level and civil surgeon of district hospital is also the nodal officer (additional charge) of IDSP leading to inadequate supervision of this programme.

v. Prevalence rate of TB is increasing in the State in last 5 years, in high endemic districts, No. of cases confirmed and put on treatment is 100%. There was lack of coordination of RNTCP with NPCDCS in visited districts.

12. Maharashtra

i. Malaria is mainly endemic in Gadchiroli, Raigarh, Chandrapur districts which alone constitute more than 70% of State malaria cases. Dengue and Chikungunya cases increased during 2015 and 2016. Number of deaths due to malaria and dengue has been quite high. Dengue is a notifiable disease; Malaria is under process of being notifiable.

ii. Large numbers of important positions are vacant in the state under all 4 major programme i.e. RNTCP, IDSP, NLEP and NVBDCP.

iii. There is lack of coordination between Municipal Corporation and Urban VBDs Scheme at Nashik (DHO) for reporting and monitoring. Entomological monitoring is lacking. Intersectoral coordination Committee had been formed under the chairmanship of District Collector, other department e.g. forest, Revenue, Education, PWD, etc. as members.

iv. Active and passive surveillance is regularly carried out by the paramedical staff e.g. MPW, ANM and ASHA. All MPW's and ASHA's are trained for use of RDT kits for diagnosis.

v. Under the Filaria Control Program, state has prepared its Filaria control plans; district level plans are also available. Ten night clinics are run in high risk areas and MF surveys are conducted regularly. ASHA not involved in the Filaria control program.

vi. Under NLEP, annual new case detection rate (ANCDR) is more than 15.65 especially in the pockets of Kuhi, Umred, Bhiwapur, which is more than the elimination level of 10/10,000. Child cases are also more than 12% of ANCDR.

vii. A total of 79 RNTCP reporting districts and 34913 DOTS Centres. 72 Gene Xpert machines have been installed for detection of TB and drug resistant TB within 2 hours. Annual case notification rate increased from 123/Lakh/year (2011) to 145/Lakh/year (2015).

13. Nagaland

i. Difficult terrain, lack of transport and communication system has adversely affected the service delivery. Reporting from periphery was substantiated by messaging through mobile phones.

ii. Active case detection by the Surveillance Workers was lacking. ANMs and ASHAs were not confident in the use of RDK. Knowledge on treatment of Pf malaria was lacking among health workers and ASHAs. Human-Vector contact was largely prevented through adequate distribution of LLINs in the villages visited but knowledge on use of LLINs amongs villagers needed reinforcement. There was non-compliance to DDT spray as the villagers did not want to spray inside the house.

iii. Weekly data entry in IDSP portal was found inconsistent in Mon district and IT equipment which was lost, have not been reinstalled.

iv. Though the prevalence rate of Leprosy cases in the state is as low as 0.33/10000, Dimapur district has reported a prevalence rate of 1.20/10000 which is the highest in the state. In Mon and Tuensang districts prevalence was 0.35 and 0.4 respectively.

v. CBNAAT was installed in Kohima DTC, Dimapur District Hospital, Mokokchung DTC and Mon District. Due to non-availability of safe place the machines meant for Tuensang and Zunhebuto districts are kept at Kohima and Dimapur.

14. Tamil Nadu

i. There is a steady decline in trend of Dengue and Malaria cases from 2012 to 2016 and substantial reduction in dengue deaths. In the State, no case has been reported of Malaria Mortality from 2012 onwards which is appreciable. However, in one of the district (Ramananthpuram) API is still more than one and in 5 districts ABER is less than 10. The state has been advised to start devising strategy for pre-elimination phase for malaria.

ii. In Tamil Nadu special focus is given on surveillance, including early detection and prompt treatment, human resource development, behavior change communication, supervision and monitoring, quality assurance and quality control of diagnostics, drugs and insecticides.

iii. 32 Public Health Labs are strengthened across the state. Surveillance is strengthened from private Health facilities.

iv. Total of 31 blocks in 16 Districts were identified as High Endemic Blocks for Leprosy during 2015-16. All existing positions are filled up. Awareness generation and screening activity are strengthened at PHC level.

v. Case finding under RNTCP has improved to 111/lakh in the year 2016 compared to 105 in the year 2015. Private notification of cases has also shown an increasing trend. This increasing trend is expected to be sustained with

utilization of new CBNAAT machines installed in all the districts of the state.

15. Tripura

i. VHSNCs are not spending funds for sanitation or filling the breeding sites. Increase of incidences of Dengue, Chikungunya & Japanese Encephalitis in 2016 is alarming, but no preparedness in the districts. The diagnosis through ELISA is confirmed at state level.

ii. Long Lasting Insecticidal Nets (LLINs) distributed and used by the community. Still deaths from Dhalai & Gomati were reported during 2016, is a great concern.

iii. Across Doctors to ASHAs-treatment Protocols for Malaria & RDT procedures not followed due lack of knowledge &/or practice. In Gomati, expired RDT was found in Sub Centre. Antimalarial Injections are preferred for uncomplicated Malaria. Most of ASHAs in Dhalai district are not having RDTs & Anti malarials and ASHAs are not aware of their incentives & are not getting Rs. 75/- for treatment.

iv. ACT-AL of all the age groups is expiring in December 2016. No short expiry list is maintained. Batch No. & expiry drug is not recorded in stock registers in half of the facilities. Stock in register & no physical existence & vice-versa was found in few facilities.

vi. District headquarter record is not being maintained properly. There is no record of patients before February 2013, no IEC material was available in the district HQ. Computer is also not available for NLEP programme.

vii. DOTS not provided to clients at all PHCs and Sub Centres, even Pharmacists are the DOTS provider in Dhalai district. Higher facility level. Designated Microscopy Centre (DMC) is not established at District Hospital Gomati in spite of availability of adequate set-up.

viii. Manipal Centre for Viral Research is conducting Acute Febrile Illness surveillance in Dhalai district for Dengue, Chikungunya, Leptospirosis, Scrub Typhus, Influenza and Malaria. The results of the tests are not communicated to either the patient or the Treating physician. Test results need to be conveyed to the patient at urgent basis to the patient, treating physician and District Surveillance Unit, as all these diseases have fatality associated and also have potential of resulting in outbreaks.

16. Uttar Pradesh

i. One area which is alarming from public health point of view is National Vector Borne Disease Control Programme. Though the programme is in place and compliant with the protocol in terms of weekly and monthly reporting but the programme is suffering from serious systemic crisis like insufficient HR, no laboratory support for chikungunya and dengue at district level, grassroot level malaria surveillance is non-existent, absences/very minimal use of vector control measures in the state, lack of training and orientation of man power etc. Attitude of the State towards vector borne diseases can be highlighted as serious bottlenecks for the programme.

ii. There is an unusual increase in the number of fever cases reported for past 2 months and there are already confirmed cases of Chikungunya in Firozabad district. Hence, it appears in the absence of any vector control measures in the state.

iii. Certain blocks of Gonda are known endemic areas for JE and Lymphatic Filariasis. But no active action was taken in this year like micro filarial survey, spray and fogging etc.

iv. Private sector is not in the network of IDSP. Urban PHCs are also not in the network.

v. There is substantial decrease in the prevalence of Leprosy

in comparison with pre-MDT era, but a decreased activity in the surveillance of Leprosy is visible. A new pediatric leprosy case is diagnosed; a laid back attitude of state may result in resurgence of leprosy.

vi. Lack of Lab technicians is one of the bottle necks in the implementation of RNTCP in Firozabad District. In majority of PHC/CHCs, there are no dedicated LT for RNTCP, they divide their week into 2-3 PHC/CHCs.

TOR 4 | NON-COMMUNICABLE Disease Control Program

OBJECTIVES

- To oversee progress of various non-communicable disease control programme activities viz. establishment of Eye Operation Theatres, establishment of NCD clinics, progress in NCD screening, implementation of COTPA, progress in district level activities under National Mental Health Programme etc.
- To assess the integration of disease control programmes with RMNCH+A initiatives, adherence to existing referral mechanisms and treatment protocol, timely payment of ASHAs, extent of engagement of AYUSH doctors in prevention and management of disease control programmes etc.

National Overview

Non-Communicable Diseases (NCD) continue to be an important public health concern owing to the changing demographic profile, socio-economic transition, increased urbanization and changes in lifestyle. The Global Report on NCDs for India 2014 reveals that Non Communicable Diseases contribute to around 5.87 million deaths that account for 60% of all deaths in India. While cardiovascular diseases (coronary heart disease, stroke, and hypertension) contribute to 45% of all NCD deaths; the other causes includedeaths due chronic respiratory disease (22 %), cancers (12 %) and diabetes (3%). The latest data from Global Burden of Diseases 2015 also put Ischemic Heart Diseases, COPD and Cerebrovascular Diseases as top three mortality causes among NCDs in India.

The National Programme for prevention and control of Cancer, Diabetes, Cardiovascular diseases and Stroke(NPCDCS) was launched in 2008 as pilot by Ministry of Health and Family Welfare under the National Health Mission after integrating the National Cancer Control Programme (NCCP) with National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke (NPDCS). As on March 2016, the programme is under implementation in all 36 States/ UTs, with 298 District NCD Cells and 293 District NCD Clinics established in the country. Also, there are 103 functional Cardiac Care Units for emergency cardiac care and 64 Day-Care Centres for Cancer care at the District levels in the country. During 2015-2016, more than 1.29 crore persons have been screened in the designated NCD Clinics. Among these NCD Clinic

attendees, around 8% were diagnosed to be Diabetics and 12% were Hypertensives. Also, around 90,000 persons were diagnosed to be suffering from cardiovascular diseases and over 13,000 persons were detected to be having common Cancers (including Oral, Cervical and Breast Cancers). During 2015-2016, around 96 lakh persons were screened under various outreach activities for common NCDs (in Camps and PHC/SC), and they were referred to higher centers for diagnosis and management. Certain good practices pertaining to NPCDCS programme exist in some States, e.g. the tele-stroke project in Himachal Pradesh, hospital based cancer registry established in PGIMER Chandigarh and in Medical College Hospital in Amritsar and functional NCD clinics in Punjab.

The National Programme for Control of Blindness, launched in the year 1976 as a 100% Centrally Sponsored scheme, has the goal to reduce the prevalence of blindness from 1.1% to 0.3% by 2020. As part of the strategy under NPCB, currently there are 248 functional eye banks across all the States, many of which are functioning under private not-for-profit organizations. Approximately 63 lakhs successful cataract surgeries have been performed, more than 8 lakhs free spectacles have been distributed to school children, and around 60 lakhs intra ocular lens (IOL) were implanted during 2015-16.

The National Tobacco Control Programme was launched during the Eleventh Five Year Plan has the objectives to bring about greater awareness on the harmful effects of tobacco use and to facilitate effective implementation of the Tobacco Control Laws (COTPA 2003). The NTCP has been implemented in 21 States covering 42 districts (2 districts per state).The Global Adult Tobacco Survey (GATS) 2009-10 shows that 34 % of adults in India use tobacco in some form, 14% adults are tobacco smokers, 26% adults covered in the survey are smokeless tobacco users. According to the available data 30% of cancer deaths, majority of cardio-vascular and lung disorders, 40% of TB and other related diseases are attributed to tobacco consumption. Over 80% of oral cancers are caused due to tobacco use. As per the WHO Global Report on "Tobacco Attributable Mortality" 2012, 7% of all deaths (for ages 30 and over) in India are attributable to tobacco. Within non-communicable diseases group, 9% of deaths are attributable to tobacco.

India has a suicide mortality rate of 20.9 per 100,000 population (World Health Report, 2016). National Mental Health Program (NMHP) was launched in the year 1982 to ensure the availability and accessibility of basic mental healthcare for all, particularly the most vulnerable and underprivileged sections and to promote community participation. The District Mental Health

Program (DMHP) was launched under NMHP in 1996 to promote early detection and treatment by training general physicians in management with limited drugs under the supervision of specialists and includes the generation of mental health awareness and sensitization among the community. Among the States visited under the 10th CRM, Delhi, Maharashtra, Madhya Pradesh and Gujarat (District Navsari) reported good implementation of NMHP. However, human resource shortage was a common concern in all these States. Roll out of the District Mental Health Programme has been initiated in Delhi.

As per reports from MoHFW, 390 Districts have been surveyed under the National Iodine Deficiency Disorder Control Programme (NIDDCP) till March 2016. Out of the 47327 iodized salt samples collected, 44795 (94%) were found conforming to the standards.

Key Findings

National Programme for prevention and control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS)

Operational NCD clinics with adequate infra-structure, human resources, drugs and diagnostic was observed inStatesof Tamil Nadu and Kerala.While these clinics have been sanctioned in other States; they remain non-functional, especially at CHC level and below (e.g. Madhya Pradesh). Difficulty in the recruitment of specialists is an important factor impeding the functioning of NCD clinics at CHC level, and to a certain extent in DHs. States show a varying degree of progress in the implementation of NCD screening for diabetes, hypertension and the common cancers (breast, oral and cervical). States and UTs like Himachal Pradesh, Tamil Nadu, Maharashtra, Madhya Pradesh, Delhi and Chandigarh have taken steps to introduce NCD screening. In Andhra Pradesh and Uttar Pradesh screening of women has been prioritized.In the majority of CRM Stateshowever, screening for NCDsis yet to be scaled up. Examples of good practice exist in some States, e.g. the tele-stroke project in Himachal Pradesh and Amma Arokiya Thittam in Tamil Nadu in which people 30 years and above are screened annually for 25 parameters (for conditions such as anaemia, obesity, diabetes, hypertension, cervical, breast and oral cancers, refractory errors, cataract and skin conditions) without any charges in the 400 upgraded primary health centres/ block PHCs.

National Programme for Control of Blindness (NPCB)

Program is being implemented in all the CRMStates. Screening activities were carried out at all the public health facilities in most of the States except in Jharkhand and Nagaland (due to shortage of specialists'). Screening for refractive errors and distribution ofspectacles were observed to be distributed in several Statessuch as Maharashtra, Madhya Pradesh, Tamil Nadu, Tripura and Uttar Pradesh. NGOs are actively involved in screening and cataract surgeries were observed to be performed in Kerala, Madhya Pradesh and Maharashtra. However, delayed payments to NGOs for their service provision is an issue in few States, e.g. Andhra Pradesh. Few States have also shown good integration of NPCB with the school health programme, e.g. Tamil Nadu, Uttar Pradesh, Andhra Pradesh. An example of good practice that other States can emulate is the tele-ophthalmology services in Tripura where IT has been successfully used to connect peripheral health facilities in rural areas with specialist eye services in secondary/tertiary hospitals.

National Tobacco Control Programme (NTCP)

In general, the implementation of the various components of this progamme is sporadic and patchy. States like Maharashtra, Tamil Nadu and Kerala have implemented certain parts of the initiative, but the holistic and robust implementation of NTCP, including IEC and awareness in community is lacking in almost all States. Integration and joint working between NTCP and NPCDCS is absent.

National Mental Health Programme (NMHP)

Some States have started to make progress in implementation of this program, eg. Tamil Nadu, Maharashtra, Madhya Pradesh and Gujarat. Roll out of the District Mental Health Programme has

been initiated in Delhi. However, overall picture in terms of NMHP implementation has been weak in the States reviewed. Key concerns include a lack of community awareness, limited screening and referrals from peripheral health facilities, shortage of trained human resources (particularly specialists) and integration with other programmes e.g. RKSK.

Other NCD programmes

There has been little progress in implementing the National Oral Health Programme in most States, except Himachal Pradesh. Its linkage with school health is weak and there are reports of irrational deployment from many States (some facilities have a dentist but no dental chairs and equipment, while other facilities in the same state/district have dental chairs but no dentist). The National Programme for Care of the Elderly also has implementation issues though some districts in States like Gujarat, Maharashtra, Tamil Nadu and Kerala have made some progress in this area.

Recommendations

NPCDCS

1. Augmenting NCD clinics particularly at sub-districts level is critical.

2. Ensure a robust supply chain mechanism of drugs, diagnostics and supplies to provide comprehensive access to NCD services – as this has been identified as a gap in most of the States reviewed.

3. Strengthen the referral mechanism of screened cases for appropriate confirmation of diagnosis, treatment & follow-up.

4. Active involvement of the community and engagement of community health workers is essential for comprehensive management of NCDs and this must be encouraged with liaison and support from local community leaders and elders.

NMHP

1. Improve coverage of the NMHP through involving and ensuring services at facilities below DH.

2. At District Hospitals, vacant posts in the Psychiatric unit need to be filled. The flexible norms and guidance provided by the GoI for recruiting specialists should be used by States.

3. Outreach activities should be planned and conducted at the district and block level regularly, and integration with RBSK and RKSK for reaching out to children and adolescent in schools and in the community under the NMHP be ensured.

NTCP

1. Ensure constitution of district tobacco control committee which meets regularly to review implementation of NTCP. These meetings should be documented with clear action points to ensure accountability.

2. Ensure implementation of COTPA in all the districts through strengthening of current monitoring arrangements.

NPCB

1. Build capacities within the public health system for cataract surgeries to reduce the reliance on NGOs and the private sector. The infra-structure and HR to deliver this should be strengthened as a priority.

2. The state needs to integrate the screening for cataract, glaucoma and other services within the general health system. ASHAs & community health workers should be actively involved in screening. In house screening for cataract, glaucoma and refraction in public health facilities needs upscaling.

3. Timely disbursement of funds to NGOs for services provided is important to ensure their continued participation.

4. Consideration should be given to including diabetes eye check-up under preventive measures to combat blindness under the NPCB.

State Findings

1. Andhra Pradesh

i. All thirteen districts are covered under NPCDCS, however state is still in process of setting up NCD cells and clinics in all the districts. It was observed that despite eight functional cardiac units and NCD clinics (in 68 CHCs) in the state, patients visiting the health facility are being attended at the regular OPD.

ii. Mahila Master Health Checkup (MMHC) program was launched by state Govt. for screening all 35+ women for common NCDs and cancers (Oral cancer, Breast Cancer and Cervical Cancer), Hypertension, Diabetes, Thyroid and other obstetric conditions.

iii. Under MMHC the focus is primarily on screening and little emphasis has been given on the management of NCDs. It was also informed that the BPL patients can seek coverage under the state insurance scheme for treatment but non BPL individuals will have to bear the cost of treatment.

iv. To ensure the screening at grass root level, capacity building of ANM & ASHAs is done through special sessions at SC every Thursday and Friday. 57 referral centres are also set up for referring all suspected cases.

v. NTCP is functional in 9 out of 13 districts of the state and there is total ban on sale of Gutka since 2011, but illegal sale of tobacco products is still a challenge in the state. Recruitment of HR has been completed in only 2 districts (Guntur and Nellore). COTPA has been implemented in the state and challan books have been issued to law enforcement agents.

vi. Under NPCB, significant proportion of cataract operations (40%) is being done by NGOs, 20% by Govt. institutions & rest of 40% patients seek private treatment. However it was noted that reimbursement to NGOs are pending since April 2014.

vii. Primary Vision Centers are being set up in the state.

Good integration of NPCB is noted with School Health Programme in Kaddaa, ophthalmic assistants are visiting government schools thrice a week to screen children for refractive errors and provide spectacles when needed. Special efforts to facilitate eye donation were noted like organizing Eye Donation fortnight, under which 3 eyeball collection centre were established (2 in private and 1 in govt. set up.)

viii. National Mental Health Programme and National Programme for Prevention & Control of Deafness are under Director of Medical Education, integration of these programmes with the NHM is a challenge at the state.

ix. Under NOHP, Dental clinics are functional at all CHCs, AHs and DHs, as well as in some PHCs. In CHCs dental clinics are running at sub optimal level due to lack of HR & equipment.

x. National Programme for the Health Care of Elderly (NPHCE) is at a very nascent stage of implementation. Equipment for setting up of geriatric unit have been supplied to 8 districts, while in other districts process to set up the unit has been recently initiated. There is high demand for geriatric care services which is catered through MMUs.

xi. Under dialysis program, one dialysis centre have been sanctioned for each district, however, currently it is operational only in 9 out of 13 districts under PPP mode. Online payment to the private partner is done for each dialysis session conducted.

xii. Under NIDD, 6 out if 13 districts are endemic with iodine deficiency disorder. The IDD cell and monitoring lab is located at Hyderabad. The process of establishment if IDD cell and monitoring lab for Andhra Pradesh is underway.

2. Arunachal Pradesh

i. Under NPCDCS, NCD cells and clinics at district level and NCD clinics at 20 out of 54CHCs have been established so far. NCD clinics at DHs and CHCs have dedicated manpower but utilization of the clinics at CHCs was reported to be sub-optimal. Counsellors posted at NCD cells were not confident enough to motivate the detected cases into treatment.

ii. In East Siang, NPCDCS units are functional at general hospital- Pasighat, CHC-Boleng, Ruskin and Nari whereas, in Upper Siang NPCDCS unit was functional at district hospital only. Approved manpower for the clinics in both the districts has not been recruited as yet.

iii. Basic equipment such as glucometer, sphygmomanometer, weighing scale, stethoscopes etc. are available in the NCD clinic at the health facilities visited. Screening of NCD cases are not done below CHC & by ASHA/ANM during community visit in urban areas. Accessibility to information in the form of display of signage, performance of NCD cell & IEC was not evident at the health facilities visited.

iv. There is no critical care unit in the state. Although 3 CCUs are approved, none have been established due to lack of funds.

v. There is substantial delay in receiving funds for the programme at the state and district level which is adversely affecting the service delivery under NPCDCS. Moreover, there is no set modality for distribution and expenditure of funds received under different programs under NCD flexipool.

vi. Under NTCP, Tobacco Cessation Centre has been established at GH Pasighat. District co-ordination unit under NTCP has been constituted with a consultant, psychologist, social worker and Data entry operator in place. Display of COTPA, non-smoking signage, penalty for violators was not visible at the health facilities visited except for GH Pasighat.

vii. NOHP is almost nonexistent in state. At the general hospital-Pasighat there is no dedicated space available for dental clinic, moreover, of the 3 dental chairs available only 1 was found to be functional. 1 BDS and 1 Dental assistant have been recruited recently under NOHP but no activity related to program has been conducted so far.

viii. National Programme for Health Care of Elderly (NPHCE) is yet to be implemented in the state.

3. Bihar

i. NPCDCS is completely defunct. NCDs are addressed as a clinical entity, not as a public health problem.

ii. Glucometers provided to the staff to diagnose/screen diabetes at the SC level are now lying idle due to non-availability of test strips.

iii. Antihypertensive and anti-diabetic drugs are also not available in institutions including the NCD clinic of medical college.

4. Chandigarh

i. Under NPCDCS, Glucometers, glucostrips and lancets have been provided at all health facilities to detect suspected cases of Diabetes. Gynecologists have been trained in VIA for screening of cervical cancer who in on the other hand will train MOs of Civil Dispensaries.

ii. Screening camps have been organized at civil dispensaries in vulnerable areas covering approximately 2.15 lakh population. Mobile Van of Radiology Department, PGI is also being used for screening of cancers.

iii. UT is planning to improve implementation of NPCDCS by strengthening NCD clinics at CHCs and SDH. Clinics at CHC, 4 Colposcopy units are planned at District Hospital; SDH & 2 CHCs while VIA units will be established at civil dispensaries for screening of Cervical Cancer.

iv. Under NPCB, cataract operations performed were double than target but reported performance is sum of cataract operations performed at PGIMER, other Government facilities and NGOs as well. Eye screening under School Health programme is being implemented but its coverage is low.

v. Under National Iodine Deficiency Diseases Control Programme, adequate number (1359) of samples of salt were collected and tested. It was found that most of the samples (1345 i.e. 99%) conformed to standards. Many educational activities were undertaken to make people aware about benefits of iodized salt.

vi. Under National Programme for Prevention & Control of Deafness, UT is in process of recruitment of staff sanctioned under the programme. Training of ANMs and Nurses and procurement of equipment under the programme are in process.

5. Delhi

i. All programs under NCD including mental health are mostly curative with very little preventive and promotive work. NCD cell is not functioning well due to issues related to integration with NHM and in adequate human resource across at NCD clinics.

ii. Under NPCDCS, GTB hospital has Diabetes and metabolic diseases unit which cater preventive, promotive & curative activities. Tertiary care units also conduct OPDs in Endocrinology, hypertension, and obesity providing curative services but they do not have any linkages with peripheral institutions and NPCDCS.

iii. Delhi State Cancer Institute was established in 2006 provides comprehensive and Holistic cancer care including counselling service for both patients & care givers. IEC activities for patients are available in facility. Care includes OPD, IPD, chemotherapy and diagnostic and evaluation services which are provided free for patients

below a particular income group. Constraints of HR and other resources have limited their resources for significant outreach activities.

iv. Tobacco cessation clinic under NTCP is not functional in any facility in either of the two districts and there is no integration of the program with preventive services. Linkages have been established with WHO sponsored Tobacco Cessation Center to run outreach programme for tobacco abusers but are non-functional because of resource crunch.

v. IHBAS is the Nodal centre for NMHP in the UT. Of the 3387 new and 44933 cases were identified under the programme only 66 cases were referred to the tertiary hospitals. The DMHP component of the national mental health program is running successfully in 5 out of 11 districts in the UT. DMHP team visits various places in different districts of NCT for delivering Meta outreach services, however, shortage in funds and HR have hampered the smooth functioning of the outreach services. IEC activities are being regularly carried out in various forms including Awareness and Sensitization camps Street plays, Posters, exhibition and pamphlet distribution

vi. Under NPPCD, the curative part of the deafness control program is taken care by tertiary care facilities. & there is no evidence of its integration with national health programs at the district level and any established referral process with peripheral institutions.

vii. Under NIDD, GTB does regular testing for iodine in salt from different samples from the district. Regular and timely feedback on the quality of samples tested is being given to the community workers from where the samples are being collected. It was observed that there is good and effective IEC under the program.

viii. Under Dialysis program, Dialysis centre is operational in Hegdewar and at LNJP hospital under PPP mode. A MoU is being signed with Deen Dayal private trust to manage the partnership, regular independent monitoring and supportive supervision visits are conducted to ensure the quality in services provided. Free services are being provided to BPL patients while others have to pay a nominal fee as per the procedure. Grievance redressal information is prominently displayed outside the dialysis rooms.

6. Gujarat

i. Overall, programs under NCDs need to get more focus and periodic reviews both at state and district level for strengthening the initiatives under the program.

ii. Maintenance of records and deaddiction centres is very good in district hospital Navsari under the NMHP but the programme needs strengthening below district level.

iii. NPCDCS program is yet to pick up the momentum as per the national guidelines. Focus is more on Diabetes and Hypertension only and that too limited to health facilities. At SDH Mansa, there is no staff at the NCD clinic. No active screening for NCDs is being done. Moreover, screening for Ca- Breast and Ca- Cervix also needs to be strengthened.

iv. NTCP implementation needs to be strengthened in the state.

v. NPCB Program is functioning as per guidelines. At DH Gandhinagar, SDH Mansa and SDH Vandsa, free cataract surgeries including IOL, provision of free spectacles and screening of school children for refractive errors has been undertaken. NMHP is functional in 16 districts of the state and is functioning well in Navsari district. It was observed that maintenance of records at the de-addiction centers at the district hospital in Navsari is very good. NMHP will be implemented in Gandhinagar

district in this financial year and needs to be implemented comprehensively at the earliest.

vi. NPOH (National Programme for Oral Health) implementation is poor. Dentist is available in SDH Mansa however without any infrastructure including dental chair since last 5 years. There is dental chair in CHC Adalaj, however the dentist position is vacant. It was informed that the recruitment is in process.

vii. NPHCE Program at the state needs to be strengthened. At the visited UPHCs, a time slot between 11 AM to 12 noon is being allotted for Elderly people to fast track OP consultations.

viii. Identification of sickle cell anemia is done on regular basis, high risk couples are identified, counseled and referred for pre-natal diagnosis. Diagnostic facilities for sickle cell anaemia have percolated down up to PHC level in Navsari district.

7. Himachal Pradesh

i. Screening camps for diabetes, hypertension and common cancers have been conducted throughout the state by PHC and sub-centre staff. The diagnostic facilities for NCDs have been made available to all patients by outsourcing the laboratory services to SRL diagnostics. Commonly used NCD drugs are available at all levels & provided free of cost.

ii. The monitoring & supervision of NCD activities at district & sub-district levels needs to be improved significantly.

iii. State has embarked upon innovative approaches like the Tele-stroke project, the Acute Coronary Syndrome (ACS) registry project and the Dialysis care centres in Public-Private Partnership Project mode. The Tele-stroke project has been already hailed as a best practice example during the last CRM and the project continues to benefit patients of thrombo-embolic stroke.

iv. Sensitization, orientation & training of all levels of personnel for NCDs is very much needed. Mandi district had a Psychiatrist and a clinical Psychologist at the district hospital level but their orientation towards the programme objectives was limited.

v. Under NIDDCP, state laboratory in Dharmshala is functional but the key state level positions are vacant. In addition, the programme implementation at the district and sub-district level was poor as the IDD kits were not available.

vi. The NPHCE activities were approved for all the 12 districts. However, the programme implementation appeared in very initial stages.

8. Jammu and Kashmir

i. Non Communicable Diseases programme was rolled out very recently and NCD clinic have established at Anantnag district and CHCs at Seer and Kokranag have NCD cells where patients are screened for Diabetes, CVD, Stroke, and hypertension. NCD camps at PHCs and CHCs at Verinag, Larnoo and Mattan carried out screening activities mainly for Diabetes and Hypertension. Drugs for hypertension and diabetes were provided free of cost.

ii. Though cases for oral, breast and cervical cancer were reported, screening facilities for cancers was unavailable even at the district level. Patients with breast and cervical were referred to Srinagar.

iii. Under NPCB, Cataract surgeries were conducted regularly. But at district hospital and the CHCs in Anantnag large number of eye injuries cases were reported from last 5 months. The ophthalmologist at the DH was conducting surgeries. However, the equipment was only for anterior segment surgeries. There is an acute need of more Ophthalmologists and an up gradation to posterior segment surgeries as large

no of patients were injured in posterior segment during the turmoil with pellets.

iv. Under NMHP, patients with PTSD, Mood disorders, Anxiety, depression were treated at the district hospital. A psychiatrist and counsellor attend the patients. Both men and women were screened, treated and counselled for the mental health problems. But supply of drugs is not regular.

9. Jharkhand

i. State and districts are yet to fix targets, initiate separate NCD clinics under NPCDCS

ii. Districts are yet to initiate educational/IEC campaign & community awareness about Cancer & Tobacco control. Poor awareness about treatment support from programme for cancer patients.

iii. Districts yet to initiate screening for RE, free glass distribution and Cataract operations. No line listing for cataract patients was seen. Unavailability of ophthalmic surgeons in districts. Seasonal camps are done.

iv. The NIDDCP is in the initial stage and the programme is providing Salt testing kits I high priority endemic districts

v. The National Programme of Health Care for Elderly (NPHCE) has been launched in the state, but has not been implemented in the monitored districts.

10. Kerala

i. NPCDCS Program is implemented effectively with functional NCD clinics at CHC and Taluka hospitals. Out-reach activities were performed at all levels through weekly clinics. SHAPE Program, LEAP, Care on Wheels Program and comprehensive screening at Chitrapuram CHC (Idukki) are being implemented.

ii. Multi Sectoral Action Plan for NCDs needs to be implemented; IEC/BCC activities on NCDs needs to be strengthened, ASHAs are required to be trained for NCDs services. Geriatric services should be extended to other centers as well, considering higher life expectancy in the State.

iii. Dialysis facilities are available at District Hospitals with provision of 17 machines, providing services to more than 90 patients in 2 shifts. But waiting time is quite long and more than 100 patients were waiting for services. State should prioritize dialysis care, considering increasing burden of Chronic Kidney Diseases.

iv. Under prevention and Control of Blindness Program districts are only involved in screening activities. Majority of cataract surgeries & outreach activities are being carried out by NGOs. State should take some measures for deploying human resource in district for carrying out NPCB activities, including cataract surgeries.

v. Under NHMP, Psychiatric/ de-addiction ward available at DH Kollam but district does not have other mental health services such as District Counselling Centre, Crisis Helpline, interventions for suicide prevention, and residential continuing care centres under DMHP.

11. Madhya Pradesh

i. Under NPCDCS, 51 district NCD cell, 51 NCD clinics and 51 CHC NCD clinics are sanctioned and established by the State but its functionality is not visible in the districts visited. NCD clinic is running only at the district hospital and caters to hypertension and diabetes screening only. For cancer patients after chemotherapy, NCD clinics are serving as a medicine dispensing units. Down below the district there is no designated NCD clinic with identified equipment's and diagnostic services and specially trained HR. Dialysis unit is available on PPP mode. The services offered are free of cost.

ii. Under NTCP, efforts have been made towards

establishing coordination with other departments of the state. Districts are following enforcement activities as per COTPA. 30 districts have district tobacco control committee but their functionality and actions were not visible in the districts visited.

iii. Under NPCB, at state level 35% achievement cataract surgeries is reported. Latest procedures like SICS and Phacoemulsification for cataract surgeries are available. Active collaborating with NGOs and PPs is observed for conducting cataract surgeries. Screenings for refractive errors are conducted in schools. In a tribal district visited by CRM team, no cataract surgeries were being done in the public health facility even after availability of an ophthalmologist. The district hospital lacked infrastructure and equipment's for conducting operative procedures for cataract.

iv. Under NMHP, State has innovated in establishing Mental Health Screening & Counselling Room (Maan-Kaksh) in all District Hospitals. Psychotropic drugs were available in the district hospitals visited and the districts are empowered to do local purchase in case of shortages. In the districts visited there was lack of outreach activities by DMHP team to CHC hospitals, targeted interventions in schools, colleges, workplaces and community.

v. Under NIDDCP, a state IDD cell is functioning and State lab is established.

12. Maharashtra

i. Under NPCDCS, opportunistic screening for hypertension and diabetes initiated till PHC level, though with variable coverage. NCD clinic is yet to be established at higher level. First line anti-HTN and anti-DM drugs available till PHC level (limited availability). Less IEC seen for cancer prevention. Protocol for DM and HTN screening not followed correctly. At SC level, opportunistic screening for HTN is mainly for ANCs.

ii. Under NPCB, refractory error screening happening in schools (RBSK). Timely procurement and distribution of glasses for beneficiaries were observed. NGOs are making significant contributions to the cataract surgery.

iii. Under NMHP, DMHP is functioning well in one of the visited district hospital. Sanctioned positions are filled, hospital with 10 beds available. On an average 1500 OPD cases per month. Drugs are available. Outreach camps conducted and Crisis helpline 104 displayed even at the SC level.

iv. NPPC is Functional in Igatpuri and One MO and Counsellor reaching to >80 patients/ month

v. For Sickle Cell Disease, requisite testing facilities are established at state level. Well established system of care in place in Nagpur. IEC well displayed. Regular Counselling carried out for newly married couples and pregnant mothers.

13. Nagaland

i. Under NPCDCS, NCD clinics were running in District Hospital. Human resource gaps were reported. Surgical management of cancer cased done, other cases referred.

ii. Under NPCB, in the previous three years the targets set at state level for NPCB could not be achieved. No ophthalmic surgeon in both districts, only ophthalmic assistants available. Cataract surgery camps were conducted.

iii. Under NIDDCP, Iodine testing of salt through STK by ASHAs carried out. Resurvey of goitre being currently undertaken. Urine sample for iodine estimation are sent to state lab.

iv. Under NPPCD, ENT surgeon is available in Mon district, but audiometrist position is vacant. Screening for defective hearing could not be carried out due to lack of other facilities.

v. NOHP coordinated with NTCP. Lack of appropriate infrastructure was reported.

14. Tamil Nadu

i. Overall functioning of Non-Communicable Disease (NCDs) programme is good in the State. All the required medicines for the treatment of the NCDs are available.

ii. The Amma Arokiya Thittam scheme covers people 30 years and above, for screening annually for 25 parameters (for conditions such as Anaemia, Obesity, Diabetes, Hypertension, Cervical, Breast and Oral cancers, Refractory errors, Cataract and Skin conditions) without any charges in the 400 upgraded primary health centres/block PHCs. The Government plans to scale it up in the whole state.

iii. NCD Screening program is functioning well for all level of health care. Women of 30 years and over were screened for cervical cancer and breast cancer.

iv. Recruitment of human resources is satisfactory at the District and Medical College Hospitals.

v. IEC materials and treatment protocol for various programmes i.e. NPCDCS, NTCP, NMHP, NPCB and NIDDCP are displayed in different health facilities of the State.

vi. NMHP and NPHCE are implemented in few districts only.

15. Tripura

i. Under NPCDCS, NCD clinics are non-functional. Procurement of equipment not done. Supply of anti-hypertensive is erratic. Only Opportunistic Screening for Diabetes Mellitus and Hypertension is being carried out. Cancer screening not conducted and ANMs not aware of cancer screening.

ii. Visibility of the NTCP programme was not there at district level neither in the form of monitoring and supervision nor IEC material linking tobacco to health hazards.

iii. NPCB is running satisfactorily at DH, where an operating Ophthalmologist is present. Under Telemedicine units, the tele-ophthalmology services are being utilized, 89276 patients were examined and 20765 patients provided with glasses.

iv. NPPCD is not yet initiated in the state.

v. NPOH implementation is poor. Adequately trained and appropriate infrastructures are absent.

vi. Under NPPC, 10 (Ten) teams comprising of Doctors, Nurses, Pharmacists & Social Workers are identified. All of them trained with the support of Expert from Pallium India & Australia Palliative Alliance. Financial support made by NHM. More than 2700 home visits conducted under the programme in 2015.

16. Uttar Pradesh

i. The NPCDCS equipment has reached upto SC level for follow up of Diabetes and hypertension in visited district. In visited district, 2 out of 12 MO positions of NCD clinics are vacant. The programme is functioning optimally even in terms of IEC activity. However there are some gaps from ANM level to NCD clinic level. The state of Uttar Pradesh has launched a programme "SAMPOORNA" in June 2016. The programme covers for screening of Hypertension, Diabetes, Anaemia, Cervical Cancer and Breast Cancer in females above 30 Yrs of age.

ii. Under NTCP a COTPA committee has been constituted and initiation for recruiting the staff under the programme has been initiated in only one visited district.

iii. Under NPCB, cataract surgery is carried out at District hospitals. Also in collaboration with NGOs charitable hospitals where IOL is provided. Screening for refraction errors are conducted at schools. However, the distribution of

spectacles has only reached 16 % in Gonda and about 25% in Firozabad in comparison with target due to constraints of resources and long lead time in supply are the reason for the same.

iv. Under NPPCF, there have been sustained activities since 2013 with IEC activity, identification of cases and safe water sources. However in 2016-17 funds have just been received and activities need to be continued.

v. Under NIDDCP, IEC material available at public places. DCM of visited district informed that ASHA's have been provided salt testing kit and trained. However, the same has not reached to all grass root workers.

vi. Programmes like NMHP, NOHP, NPHCE, NPPC, NPPMD, are not in place due to non-initiation and or resource constraints.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TOR 5 | HUMAN RESOURCES for Health and Training

OBJECTIVES

- To review HR policy, structures and systems, adequacy of HR against requirement, efforts put in implementing health systems approach
- To review recruitment practices, competency based skill assessments rational deployment of skilled staff, implementation of HRIS, performance assessment, ANM work charter, and Performance based incentives.
- To assess the capacity of training institutions and its utilization, progress in the trainings approved so far, selection and training of mid-level providers

National Overview

This TOR reviews the HRH and training components of health systems strengthening and the NHM contribution in this regard through the prism of (a) the availability and adequacy of human resources in the public health system (b) training and capacity building and (c) the management of the HR workforce.

A. Availability and adequacy of HRH

Since its inception a decade ago, the NHM has made a significant contribution towards addressing the shortage of the health workforce in the public health system. It has also helped to strengthen administration and management of the health system through the provision of programme management units at state, district and block levels. An estimated two lakh additional medical, nursing and para-medical personnel have been added on a contractual basis through the NHM (Source: NHM state wise progress as on 30.06.2016). This has helped to address shortages in some areas, but significant gaps remain in others, e.g. a lack of specialists (84% vacancies) in secondary public health facilities observed in Bihar.

States are yet to take full advantage of initiatives such as the flexible norms for engaging such specialists as recommended in recent MoHFW guidance. States

should continue to strive towards augmenting human resources in public facilities along the norms set in the IPHS standards.

Many States still recruit health professionals for delivering single issue vertical health programmes. A health systems approach towards strengthning HR is needed where the emphasis is on the integrated delivery of public health services with functionaries working across various programmes to deliver holistic care. The CRM review this year shows that some States like Andhra Pradesh have made an effort to offer integrated multi-skilling of health workers e.g. for laboratory technicians. This effort needs to be scaled up in other States and also include other categories of health professionals like counselors.

Strengthening the human resource element of public health systems requires a focus not only on the quantity, but also on the quality and competence of the employed functionaries. Initiatives such as the empanellment of external HR agencies to support States with large scale recrutiments will help address the quantity gap whereas the introduction of competency based skill tests will help to ensure that the competence of the inducted health professionals is of a standard to ensure high quality health service delivery through our public health facilities. Bihar and Maharashtra have already included skill based competency assessment as part of recruitment of skillcare providers while Arunachal Pradesh, Madhya Pradesh and Uttar Pradesh are using Competency assessment tests for identifying skill gaps of the existing staff.

B. Training and Capacity Building

High quality pre-service training ensures service delivery meets acceptable standards; accredited in-service training ensures health professionals refresh their skills in line with latest developments in the health sector. With the mushrooming of private medical, nursing and para-medical schools and colleges, ensuring high quality pre-service training needs more stringent implementation of regulations and adequate monitoring.

Some States have well developed systems for in-service refresher training; in most States however this needs considerable investment and focus. Training provided under various national health programmes if often not linked to training needs assessment of relevant health professionals; the limited functionality of SIHFWs (the state nodal agencies for training) remains a challenge.

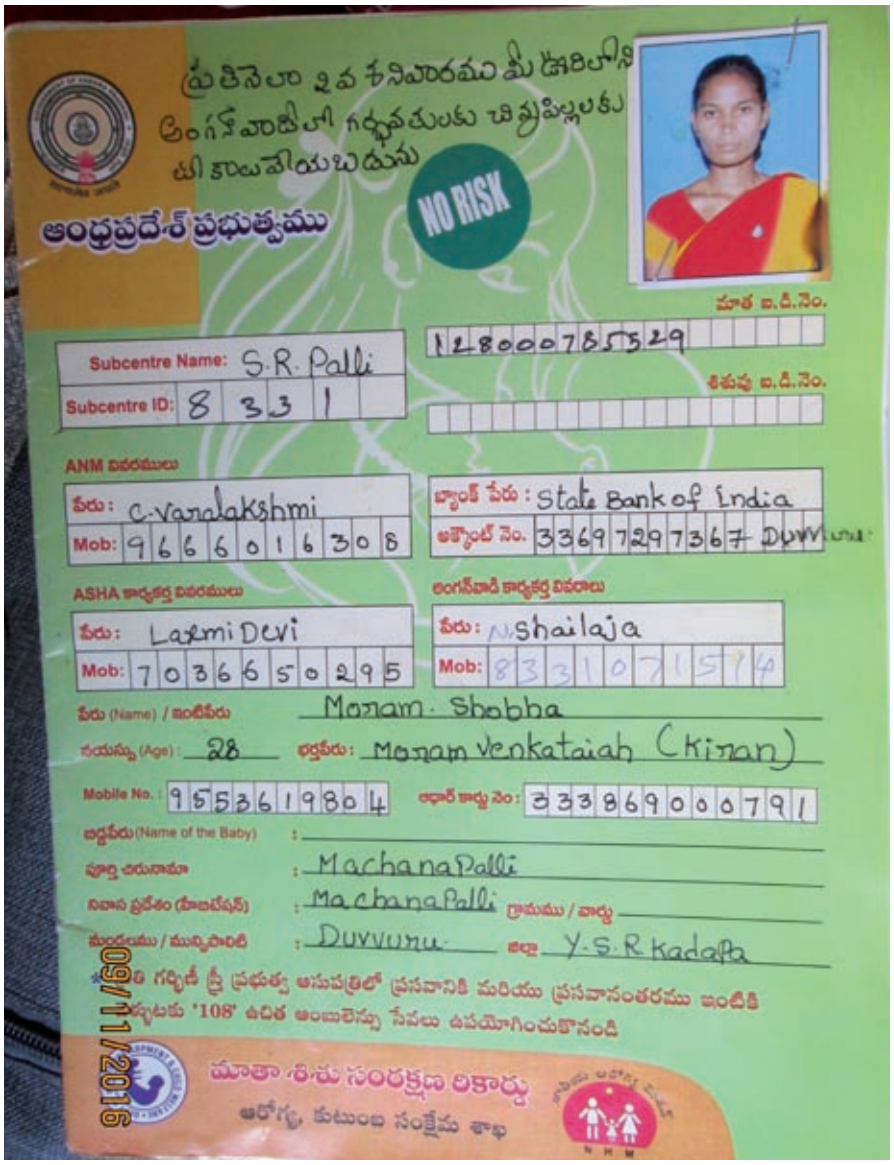
A significant shortage of trained faculty has been reported at States like Andhra Pradesh, Delhi, Nagaland, and other training institutes compromises the ability of States to train an adequate number of its in-service staff members. Training support and facilities in govt. nursing schools and colleges needs augmentation; in addition, training institutes for the MPW (Male) need to be revived if we are to truly provide comprehensive primary care close to the community - as envisioned by the government. J&K has an excellent training infrastructure at all levels. The regional centres are equipped with world class simulators to train medical, nursing, paramedical and other healthcare workforce and regular trainings on Basic Life Support (BLS), Emergency Room Trauma Course (ERTC) & Advanced

Cardiac Life Support (ACLS) are provided for doctors, technicians and paramedics etc. through skill labs

C. Workforce Management

This is essential to maintain the morale of our public health professionals and ensure a fair, transparent and employee-friendly working environment. A comprehensive human resource policy along with rotational transfer for all staff is either lacking or not robustly implemented in many States. This primarly affects high priority districts, which face the human resource crunch from deficient and adhoc implementation of postings and transfer policies. These should be transparent, fairly implemented and linked with performance appraisal and achievements rather than being merely time-bound promotions and transfers.

Apart from recruitment, the retention of health workers in remote and rural areas continues to remain a challenge. The role of adequate financial and non-financial incentives to address this issue cannot be over-emphasized. NHM reviews, surveys and media reports show that some States have taken innovative steps to provide various incentives to retain health professionals; these needs to be strengthened and scaled up across other States to prevent the drain of otherwise dedicated and competent health workers towards the private sector.



While many States have made progress towards the establishment of a Human Resource Management Information System (HRMIS), further work is needed to make them comprehensive and take full advantages of its features; this should be complemented by linking it to a Training Management Information System (TMIS).

State HR cells are poorly resourced and stretched thin. This makes it difficult to ensure HR gap analysis, timely recruitments and provide adequate workforce management. States have yet to give the establishment of HR cells adequate priority at the state, district and block level.

This CRM review has shown that some States like Uttar Pradesh, Kerala and Tripurahave made a move towards linking performance appraisal with contract renewal. This is a welcome step and needs to be strengthened and adopted across all state public health systems.

Some States/UTs like Chandigarh have also shown initiative in ensuring pay parity for staff members in the same category working across different national health programmes. This is strongly encouraged to restore the morale of functionaries.

A public health cadre has been shown to improve public health outcomes and indicators both internationally and in the States which have adopted these nationally. Recent CRM reviews have shown that while some States have expressed an interest in establishing these, the pace of progress in this regard needs to be stepped up.

The NHM has made an important contribution towards addressing the shortage and skill gaps through its contractual workforce. Ensuring pay parity and providing incentives and mechanisms to induct them in to the regular cadre of state public health systems will keep the contractual workforce motivated and provide a sustainable health workforce for the state.

Key Findings

A. Availability of HR

i. To fill service delivery gaps, States are adopting various measures like (a) contracting specialistson-call(Chandigarh); (b) appointing AYUSH MOs at PHCs (Bihar); and (c) providing benefits such as mobility support, weekly offs and fixed tenure postings to specialists (Andhra Pradesh).

ii. States such as Andhra Pradesh have also taken welcome initiative of providing preference to in-service NHM staff in recruitment for regular positions through provision of grace marks.

iii. Many States including Andhra Pradesh, Bihar and Maharashtra are providing relaxation in higher education to in-service MOs who have served in rural areas.

iv. Despite streamlined procedures to scale-up HR, significant vacancies of service providers observed in most of the States including Andhra Pradesh, Bihar, Gujarat, Maharashtra, Madhya Pradesh, Nagaland, Uttar Pradesh, Jharkhand, J&K, Himachal Pradesh, Tamil Nadu, Tripura and Kerala.

v. States like Andhra Pradesh and Maharashtrahaveconsiderable number of vacancies for administrative posts while in Bihar, shortage of program specific HR was reported as hurdle in implementation of national programs.

vi. In some States like Arunachal Pradesh and Nagaland, sanctioned posts are lesser than required numbers as per IPHS norms due to long pending cadre revisions.

vii. Shortage of Family Planning/ RMNCHA Counselors was seen in Bihar and Gujarat. As an interim measure, Bihar is plugging service delivery gaps through training ANMs in Family Planning counseling.

B. Training and Capacity Building

i. Maharashtra has taken the unique initiative of conducting post training evaluation of the skills of trained staff through an evaluation tool. Faculty from the state's apex-training institute (Public Health Institute Nagpur) visits the staff working at facilities and conduct evaluation through the tool.

ii. Maharashtra has also adopted a unique model for addressing specialist shortages through College of Physicians and Surgeons. The fellowships, diplomas and certificates in clinical specialties awarded by the college, although not recognized by the MCI, legitimize the doctors to practice specialist skills with in the state.

iii. Integrated multiskilling of LTs have been done in Kerala while Andhra Pradesh plans to do the same for LTs, Counselors, etc. as a step towards Health Systems Approach to HRH strengthening.

iv. Training Need Assessment is lacking in Andhra Pradesh, Arunachal Pradesh, Kerala, J&K and Himachal Pradesh.

v. Shortage of trained Human Resources and training

infrastructure (including State Training Institutes) in Andhra Pradesh, Arunachal Pradesh, Chandigarh, Delhi, and Kerala were seen as hurdles in achievement of training targets. No trainings have been conducted in Nagaland for the past two years

vi. Low utilization of specialized skills was reportedly due to non-relevant postings. Doctors trained in CEmOC and LSAS are posted in non-FRUs which has been leading to non-utilization of skills imparted (Bihar, Gujarat etc.)

vii. MPW Training Centers are being shut down in Madhya Pradesh.

C. Workforce Management

i. HRMIS has been established in most of the States including Bihar, Delhi, Gujarat, Himachal Pradesh, Maharashtra, Madhya Pradesh and Uttar Pradesh. TMIS has also been developed in Maharashtra and Uttar Pradesh but is not yet linked with TMISStates like Maharashtra and Tamil Nadu have established Public Health Cadre. Gujarat is working on setting up Public Health Cadre and Program Officers at all levels have been trained in Public Health.

ii. Skill based competency assessment tests are being conducted in Arunachal Pradesh, Madhya Pradesh and Uttar Pradesh for identifying skill gaps among in-service staff and for planning corrective trainings. Competency assessments are conducted as part of recruitment of skilled care providers in Bihar and Maharashtra only.

iii. In Uttar Pradesh, Kerala and Tripura, annual performance appraisal has been linked with the renewal of contracts of staff. But Performance Appraisal Mechanism was lacking in Andhra Pradesh, Arunachal Pradesh and Bihar.

iv. LTs have been given integrated multiskilling straining and are providing services across programs in Andhra Pradesh, Bihar and Kerala while J&K is in the process of doing so. Similar integration in counseling services was missing across the States.

v. Chandigarh has taken initiatives for bringing pay parity for Data Entry Operators and LTs engaged under all programs but in Delhi pay disparity among regular and contractual staff were seen as a cause of resentment among staff.

vi. Lack of robust HR Policies and dedicated/empowered HR Cells has affected effective HRH Management.

vii. There was a felt need of induction training and job description of HR in many States including Arunachal Pradesh, Himachal Pradesh and J&K.

viii. Lack of decentralization has resulted in delayed recruitment process in Bihar and Delhi.

Recommendations

A. Availability of HR

i. Non-financial incentives to increase retention of doctors in rural areas in terms of - reservation policy and preference for post graduation opportunities given to candidates who have served in rural years for 2-3 years should be considered. To attract and retain healthcare workforce especially doctors certain financial and other job related incentives including mobility support, weekly off days and fixed tenure postings can be undertaken.

ii. Measures to address shortage of specialized human resources in health it is recommended that the proposed specialization courses like DNB may be fast tracked to equip doctors to fill the gaps. Specialist courses run by the College of Physicians and Surgeons in Maharashtra may be reviewed by other States for adoption, if found suitable Flexible norms under NHM to engage specialty services in secondary care facilities may be adopted by States

iii. An initiative of providing preference to in-service NHM staff for recruitment of regular positions by providing grace marks as undertaken by Andhra Pradesh may be explored by other States.

iv. The state training policy needs to be in aligned to government guidelines for multiskilling key staff and quality assurance trainings. Multi skilling staff can mitigate the shortage of human resources as they can work across various national health programs. It is imperative that the newly recruited staff should be made to undergo induction training on NHM.

v. There is significant number of vacancies across many States, which need to be filled on priority to according to IPHS norms. States can engage HR Recruitment Agencies empanelled at the National Level under NHM for their large scale recruitments.

B. Training and Capacity Building

i. There should be a comprehensive training plan formulated along with TMIS (Training Management Information System) to monitor and track training activities. Post training evaluation of skills also needs to be done to assess efficacy of the training.

ii. Training needs assessment has to be done after assessing the competency skill gaps in existing HR for optimal improvement in healthcare service delivery.

iii. Setting up Training Institutes in States where none exist (Andhra Pradesh, Arunachal Pradesh) and strengthening existing ones with necessary infrastructure and adequate HR including faculty, technical consultants, trainers, etc. will go a long way in ensuring required frequency and quality of various types of training across different cadres.

iv. The Multi Purpose Worker (MPW) training centers need to be revived so as to ensure availability of HR for comprehensive primary health care.

v. Rational posting of appropriately trained HR at appropriate levels of health facility to guarantee utilization of their skills and expected range of service delivery e.g. EMOC and LSAS trained Doctors in identified FRUs.

C. Workforce Management

i. States should move towards creation of separate Clinical and Public Health Cadres with well-defined career pathways. Tamil Nadu and Maharashtra have gained from having separate cadres. NHM also provides financial incentives to States for this initiative.

ii. A comprehensive human resource policy along with rotational transfer policy for all staff is recommended. High priority districts are facing human resource crunch due to lack of robust transfer policies. The postings, promotions and transfers policy needs to be transparent and linked to trainings, skill assessment and performance appraisal rather than merely based on time-bound promotions.

iii. HRMIS (Human Resource Management Information System) needs to be set up and integrated with TMIS. Functional requirements of HRMIS framed by the MOHFW may be referred to.

iv. An integrated training approach (e.g. LTs and Counselors) is the way forward for equipping care providers with necessary skills to work for various programs.

v. All States should establish Performance Appraisal Systems for contract renewals and financial increments for all categories of technical staff.

vi. States should consider implementing pay parity across cadres between contractual and regular staff, as has been done in Chandigarh.

State-wise findings

1. Andhra Pradesh

A. Availability of HR

- State provides preference (through grace marks) to the NHM staff in recruitment for regular positions, which is an encouraging step towards attracting contractual employment in rural areas.
- In order to increase retention of doctors in rural areas, the state has a policy of reservation in PG seats for Medical Officers (MOs) having served at least three years in rural areas
- Most of the regular posts are lying vacant in state with vacancies of over one-third of sanctioned posts of doctors and over half of sanctioned posts of specialists.
- Bifurcation of the state has left many senior administrative posts at the state level vacant - only 1 Additional Director out of 4 sanctioned posts and 1 Regional Director out of 4 sanctioned are currently in place.

B. Training & Capacity Building

- State plans to conduct integrated multiskilling of health workers, e.g. LTs, Counsellors, etc. as a step towards Health Systems Approach to HRH strengthening.
- Training Calendar was present but Training Need Assessment was missing. Mechanism of Post training supervision/ follow-up also not in place.
- The progress of training achievement is low - only 40% training is completed till November 2016. Although there is a one PO DTT appointed as nodal officer for trainings at district level but there is shortage of skilled staff/master trainers to conduct trainings.
- After bifurcation, state is not left with any state level public health training institute. The only apex-training institute was in Hyderabad, which has now gone into Telangana after bifurcation.

C. Workforce Management

- Clear work division was observed between the two ANMs posted at Sub-centres.
- In addition to the provision of increased salary, Specialists are also provided non-financial incentives including mobility support, weekly off days and fixed tenure postings for attracting them into services.
- Although there is a provision of online payment of salaries in the state, it is yet to establish Human Resource Management Information System (HRMIS).
- Competency based selection process and performance appraisal mechanism is lacking in the state.

2. Arunachal Pradesh

A. Availability of HR

- Due to long pending restructuring of MO cadre, the state has lesser than required number of sanctioned posts of specialists. Many GDMOs, who had completed PG while being in service, are still working at GDMO posts because there wasn't any provision of rejoining in Specialist cadre while also considering their seniority in service.
- Sanctioned posts of Staff Nurses are lesser than required in state with respect to IPHS norms. Strengthening of Nursing schools and increase in their seat intake is required to fulfill the rising needs.

B. Training & Capacity Building

- There is no apex public health training institute (SIHFW) in the state. Training Need Assessment not being done for planning of training. Role of NGOs have been active in providing quality training to staff in state.

C. Workforce Management

- Skill tests are conducted for the in-service staff but its application for recruitment of ANMs, SNs and LTs and for taking corrective trainings is not being done.
- ANM Work Charter was not found present in state and thus

there was lack of clarity in work distribution between ANMs.

- There is no system of orientation of newly joined staff on their expected roles. No Job description available for the existing posts in state.

- There is no system of performance appraisal of contractual service delivery staff.

3. Bihar

A. Availability of HR

- State has appointed AYUSH doctors at 1384 Additional PHCs under mainstreaming of AYUSH who also provide primary health care at facilities in absence of allopathic doctors.

- As a retention strategy, state has reserved 50 % of the PG diploma seats for in-service doctors.

- Despite of shortage of Psychiatrists, the state has been able to run Mental Health Programme through roping in Psychiatrists from Medical colleges and other places in districts.

- There is huge shortage of Specialists - 84% of regular posts and all contractual posts of Specialists (Gynecologists, Pediatricians, Anesthetists) are lying vacant in the state.

- Unavailability of Human Resources has become major hurdle in implementation of various programmes in state. All posts of Epidemiologist, State/District Programme Coordinator are vacant under NPDCDCS in state. NPHCE (Elderly care), NTCP (Tobacco control), IDSP and RNTCP also facing similar shortages in programme specific HR.

- State has been unable to fill all approved posts of RMNCHA counselors and therefore as an interim measure, ANMs are being trained in Family Planning counseling for providing counseling.

- Although the state has upgraded various medical colleges and increased MBBS and PG seats, but still the generation capacity is far from the required.

B. Training & Capacity Building

- ANMTC West Champaran was found lacking in basic amenities such as bedding, ventilation and food facility. Overcrowded hostel with compromised and unhygienic living conditions were leading to skin ailments among the residents.

- Doctors trained in CEmOC and LSAS are posted in non-FRUs which has been leading to non-utilization of skills imparted.

- There is felt need for training Service Delivery staff on waste management, infection control protocols, etc.

C. Workforce Management

- Competency based skill assessment tests are used for recruitment of skill care providers but the same is not yet used for skill gap assessment of in-service staff for deciding on corrective trainings.

- Services of LTs were seen integrated across programmes beyond the programme under which they were hired. LTs under RNTCP were seen doing routine tests other than the tests under RNTCP.

- Web based HRIS is in place for informing decision-makers for HR planning, training need assessment, postings and transfers in the state. However, HRIS is not yet integrated with TMIS in state.

- Decentralized recruitment of MOs and SNs through weekly-held walk-in interviews is discontinued in some districts owing to limited capacity of district health administration for handling extra administrative burden. Recruitments conducted at state level are time-consuming because of delayed roster clearance exercise at district level.

- District Health Officials don't have authority to depute staff within the district based on needs. This is resulting in various specialists irrationally placed at higher care centers rendering them non-functional.

- There is no performance assessment mechanism followed in state.

4. Chandigarh

A. Availability of HR

- UT utilizes GOI's flexible norms for contracting Specialists on-call basis for conducting C-section deliveries
- Regular posts in UT are filled by the UPSC, which is a time-consuming exercise. Posts under NHM are filled by walk-in interviews.

B. Training & Capacity Building

- UT doesn't have any apex-public health training institute for providing training to Service Providers. Govt. Medical Colleges is utilized for the purpose of training.
- TMIS is not yet in place for managing and updating training database and planning trainings.
- There is no system of supportive supervision after training to ensure that the trained skills are practiced properly by care providers.

C. Workforce Management

- The provision of posting NHM staff nearby their residential areas have helped the UT curtail avoidable transfer requests.
- UT has taken initiatives for bringing pay parity for Data Entry Operators and LTs engaged under all programmes.
- There is a system of performance appraisal of contractual staff (technical and non-technical)
- The outsourced staff gets lesser salary than their counterparts engaged under NHM and regular services.
- UT has not taken any steps towards rationalization of existing human resources.
- Currently, the UT doesn't have HR MIS to capture and record HR information but it is planning to adopt Manav Sampada application from Himachal Pradesh.

5. Delhi

A. Availability of HR

- There is improvement in availability of doctors and nurses as compared with the last year.
- There is a felt need of Biomedical engineers in Health department who could look after the repairs and maintenance works of the biomedical equipments placed at facilities.
- One SNCU in Delhi is not functioning properly because of shortfall of HR.

B. Training & Capacity Building

- Trainings are being conducted at the 4 identified training centers at state level and at 4 district training centers.
- Shortfall in HR at Health and Family Welfare Training Centre (HFWTC) has been leading to low achievements in training.

C. Workforce Management

- Job Description as well as the TOR has been developed for each position.
- State has a Human Resource Information System (HRIS) covering information on HR working in all facilities.
- Disparities in remuneration among regular and contractual staff were reported to be the cause of resentment among the staff.
- In absence of transfer policy of contractual staff, there is no provision of rotation of staff across facilities even if it is needed.
- Recruitment is centralized at the state level, which makes it a time-consuming exercise for the districts to get approvals and conduct recruitments at the state level.
- The state sources HR from the State government, NHM and MCD but there is no combined source of mapping HR from the three sources. This makes it difficult in rational distribution of HR across facilities.

- There are issues in deployment of staff rationally as per the Caseload of facilities. Instances were reported where nursing staffs were dispensing medicines for the last many years.

6. Gujarat

A. Availability of HR

- The recruitment of LTs, Pharmacists, and ANMs is decentralized at district level while Specialists and MOs are recruited at divisional level through walk-in interviews held every month.
- Despite streamlined and decentralized recruitment procedures, huge vacancies of Specialists, Doctors, LTs, Pharmacists, Radiographers, ANMs, MPWs and LHVs are observed in the state.
- Family Planning/RMNCHA counselors are not in place in most of the facilities.

B. Training and Capacity Building

- State has excellent training infrastructure with an apex-training institute as SIHFW, 4 Divisional training institutes and 1 Health and Family Welfare Training Center. There are 6 skill labs established in States where 32 skills are demonstrated.
- Low utilization of specialized skills was reportedly due to non-relevant postings. Of 103 MOs trained in EmOC, only 13 are doing C-section and out of 54 MOs trained in LSAS, 38 are administering spinal anesthesia.
- GNMs working in labor room at a few facilities were not trained in Skilled Birth Attendance (SBA).
- There is felt need of refresher training for ANMs posted at Sub-centers (SCs) in providing basic ANC services. ANMs at some SCs were not found properly skilled to undertake hemoglobin estimation and abdominal examination of pregnant women.

C. Workforce Management

- State has identified 77 high priority Taluka and made it mandatory for the MOs and Specialists to complete minimum 2-3 years of their service therein. Staff under NHM is also provided initial postings in high priority areas.
- HRMIS is in place, which captures and maintains HR information on regular HR only. The process of capturing contractual HR information in existing HRMIS is underway.
- The state is working on setting up Public health cadre. Currently, Programme Officers posted at Taluka, District, Divisional and State level are all trained in Public Health.
- There is no TMIS for capturing/ maintaining training database, planning and monitoring training. Currently state is in the process of developing the training software.

7. Himachal Pradesh

A. Availability of HR

- ANM and MPW(M) are available in SCs
- As against the sanctioned norms there are no doctors in some PHCs and CHCs. Well developed Infrastructure has not been put to optimum use because of numerical inadequacy of the required HR
- Irrational up gradation of PHC/ CHC has also added to the acute shortage of required HR.
- The State needs to examine the process of induction of contractual HR, supported under the NHM, to shorten delays in their induction. Revision of Health HR policy is strongly recommended.
- There can be utilization of existing HR in Medical Colleges to provide services at health facilites to encounter the problem of shortage of HR e.g. There can be residential posting option for Post Graduates & Senior Residents etc

B. Training and Capacity Building

- It was observed that the GNMs posted in labour room are not

trained in Skilled Birth Attendant (SBA), NSSK and in FBNC.

- Capacity building of district and sub-district program managers focusing on monitoring & supervision needed.
- The knowledge and skills of ANMs posted in the SCs are not upto the mark particularly in respect to abdominal examination
- Need based training is to be planned to improve the service delivery.

C. Workforce Management

- The state has a functional web enabled HRMIS
- The remuneration norms for contractual staff needs to be reviewed
- The proposed specialization courses like DNB need to be fast-tracked to increase availability of specialists.

8. J&K

A. Availability of HR

- The state has an adequate number of sanctioned positions as per IPHS
- The available healthcare manpower is providing uninterrupted services irrespective of difficult conditions. As an incentive they are being provided free pick and drop services (due to civil unrest). Also difficult area allowance is being provided to doctors posted in remote areas, but no such provision is existing for nursing or paramedical staff.
- The HR integration across various national health programmes under NHM is still in process
- More than 50% vacancies are existing for staff nurses, physiotherapist, audiologists, optometrist, counselors.
- The state has constituted committee for conducting recruitment of NHM staff. However the recruitment process lacks skill based competency assessment. Preference is given to candidates residing in same district/block.
- None of the staff had been provided with a job description and had no knowledge regarding national health programs, hence affecting the quality of services.
- Improper allocation of HR has led to overstaffing and under staffing in health facilities.

B. Training and Capacity Building

- Two regional training institutes along with district training centers are in place along with 11 government ANM schools.
- There is a provision of world class simulators & skill lab to train medical, nursing, paramedical & other health workforce in RIHFW, Kashmir.
- There is no mechanism of training needs & competency skill assessment of staff

C. Workforce Management

- The performance appraisal system is running effectively in Kashmir division but not in Jammu. It is not linked to the competency assessment of the staff.
- Annual appraisal mechanism to be strengthened and linked with job description,training and development needs of staff.
- The process of setting up HRMIS for the state is in process.
- An amendment needs to be in the contract clause for female candidates asking them to submit affidavit regarding marital status & residence duly attested
- There is a need to frame the HR policy for the state.

9. Jharkhand

A. Availability of HR

- The recent appointment of MPWs have improved the healthcare services uptake especially communicable diseases
- There are long standing vacancies of regular and contractual staff which have

led to improper management and thus underutilization of health services.

- Deployment of the staff for optimizing healthcare delivery is another challenge
- Due to shortage of HR the doctors serve 2-3 institutions in a week hence due to non availability of doctors, patients are often turned down

B. Training & Capacity Building

- Sahiyas are being regularly trained on various modules, but for other cadres all capacity building programmes are lagging behind except Kayakalp Training.
- The skill labs are in the process of being established.
- Newly appointed health care personnel do not undergo any induction training which would orient them towards national health programs

C. Workforce Management

- The state has to formulate an HR policy backed by a robust HRMIS to effectively mange Human Resources for health
- There is no transparent system of postings and transfers.

10. Kerala

A. Availability of HR

- State has a transparent and decentralized recruitment system in place. Recruitment is decentralized at the district level and DPM is the nodal person for all recruitments under NHM.
- Integration between the Directorate of Health Services and National Health Mission is commendable. It has remarkably contributed in improving availability of services.
- The District Programme Managers are appointed from the regular Medical Officer cadre from DHS, which has helped in their sustainability, and better understanding of the public health issues for taking timely appropriate measures
- Though there are vacancies in the state for both regular and contractual staff, there is adequate sanctioned manpower to cater to the delivery points in the state. But still there is a need to increase the sanctioned post in the regular cadre as per the IPHS norms.
- Monthly ASHA Honorarium was introduced in the state since last two years. Currently Rs. 1500/- is paid to all ASHAs in addition to their incentives
- State needs to undertake a rational deployment exercise, especially in its high priority blocks, so as to ensure service provision through a full complement of human resources. Some facilities which have been upgraded to higher level or are providing additional services should ensure corresponding increase in the available HR.
- Multi-skilling of Lab Technicians was observed in the Idukki District. However, there is no integration of work for the counsellors. All the counsellors are providing services only in their respective service areas.
- There is a need to develop Comprehensive Human Resource Policy including rotational transfer policy for all the staff. High priority districts are facing human resources crunch due to lack of a transfer policy.

B. Training & Capacity Building

- The state is in the process of implementation of TMIS. Collection of data from the district is under way and currently data has been consolidate for 4 out of 14 districts.
- State to undertake strengthening of its nursing institutions (especially public sector) in line with the GOI roadmap for strengthening nursing cadre.
- The Annual Training Plan is prepared at the state level by SIHFW, but does not take into account the training needs of Department of Health Services, SHS and the facilities. Lack of coordination between State Health Society (SHS) and SIHFW was observed.

- Since 2015-16, SIHFW has not received NHM funds hence trainings are being conducted only from the plan funds while NHM trainings have been decentralized at the district level.

- Currently, SIHFW is conducting only the orientation trainings. A skill lab has been developed by SIHFW to provide technical trainings however there is shortage of necessary equipment and staff to make it functional.

- Lack of well-equipped training infrastructure (Skill lab, IT lab & library) has been observed in School of Nursing (Muttom, Idukki District).

- Post training monitoring should be strengthened. There is a need of training needs assessment of service providers at delivery points and rationalizing training plans at District & State level.

C. Workforce Management

- A team of DPM, DMO, Deputy DMO, Technical officer or Nodal officer of the relevant programme and one person from the Ministry of Health, Chennai or Trivandrum is informed at the time of recruitment. Depending on the programme for which recruitment is done, the nodal person replaces the Deputy DMO.

- Written test is conducted for staff including Staff Nurse, JPHN, Pharmacist, Lab Technician, School Health Nurse (RBSK), and PRO/Liaison Officer. Some recruitments are also done at the State level for the districts including Dental Surgeons and AYUSH.

- The State has developed a software "NHM MIS" which works like a database for all the contractual staff in the State. Reports can be generated post and facility-wise.

- The State has also developed a software "HR APP" which is used for payroll management of contractual staff mainly Programme Management staff. Request such as leave, out of office, etc. is made using this software and the Admin and HR Manager is the nodal person for approval. Salary slips are also generated through this software. However, currently it is being used at the State level only although the information of the programme management staff in all districts have been uploaded in the software. There is a need for integration between the HR APP and NHM MIS. Moreover, HR APP needs to be strengthened to include service delivery staff as well as details of staff under DHS.

- There is a pre-existing performance and appraisal system. Contracts are renewed on the basis of the appraisal using the performance appraisal form available at the DPMSU. The format includes a score card based on which contracts are renewed. Contract for the staff with score above 75% is renewed as per requirement while for staff with score between 50% to 75%, contract is renewed for 3 months and re-assessment done after 3 months. Contract is not renewed for staff with score below 50%. This mechanism is followed across the State.

- For staff recruited through HMC & RSBY funds, there is no formal appraisal. Decision is taken by the committee based on the performance and accordingly contract is renewed.

- Transfer policy is in place, only for PROs and Coordinators, wherein after completion of 3 years the staff is transferred to another facility/block within the same district.

- There is no comprehensive Human Resource Policy available at the State level with regard to rational posting and promotion of all the staff.

11. Maharashtra

A. Availability of HR

- As a retention strategy, state provides additional 10% marks and reservation in PG admission for in-service candidates working in rural areas.

- More than half of the District Health Officer/Civil Surgeon posts are vacant in districts. In addition, more than three-fourth of specialist posts and

one-fourth of medical officers' posts are lying vacant in state.

- State has stopped contractual appointments for the last few years.

B. Training & Capacity Building

- Maharashtra has excellent network of training institutions with Public Health Institute (PHI) Nagpur as apex center at state level, 7 Regional HFWTCs and 34 District Training Centers, 23 Hospital Training Centers and 7 Block Training Centers.

C. Workforce Management

- Skill based competency assessment tests are conducted for recruitment of MOs, Nurses and Paramedical staff under NHM but such tests are not used for performance appraisal of in-service staff.
- State has a web based HRMIS system, which captures and maintains information only for contractual staff.
- State has a public health cadre and public health training of MOs working in Health/ administrative/management posts is being undertaken with help of State-owned Yashada training academy at Pune.
- For the purpose of evaluation of skilled care providers' skills post training, an evaluation tool has been developed. The tool is used by PHI faculty to assess performance of trained staff at their workplaces.
- The recently developed TMIS has not been operationalized as yet for the staff is being trained on its application currently.

12. Madhya Pradesh

A. Availability of HR

- Considerable shortage of doctors in the state - over two-fifth posts of regular doctors and over two-third posts of specialists lying vacant in state.
- State has recently reduced retirement age of ANMs from 65 to 60 years, which has impacted on their availability in public health facilities.

B. Training & Capacity Building

- Training Centers for MPW have been shut down in the state.

C. Workforce Management

- HRMIS is established in the state and HR information entries made but the database is not updated for the last 3-4 months.
- Competency assessment tests are being held in the state but there is lack of information if the same is being utilized for taking corrective trainings and for selection of skilled staff.

13. Nagaland

A. Availability of HR

- Out of the 1752 (R) sanctioned posts, 1751 are filled; under NHM, out of the 861 approved posts; 742 are filled. However, the state may sanction more posts under regular cadre keeping in mind the IPHS requirements.
- State does not have a specialist cadre. There are 111 specialist in position(106-regular; 5-contractual). State has approved 41 specialist positions but has been able to recruit only 5 specialist doctors due to retention issues in hard working areas. The state has also not requested any support in PIPs to provide incentives to increase retention to specialist doctors.
- In many districts irrational postings were observed along with unclear workload allocation.
- The absence of constant leadership for three years for key posts as mandated by the state rules was not being observed as in case of Mission Directors, hence there was discontinuity in translation of health services

B. Training & Capacity Building

- No trainings have been conducted in the state for the past two years
- Refresher training for ASHA & ANMs is a necessity as they

lack knowledge and skills required for fulfilling their job responsibilities

C. Workforce Management

- Actions for integrating HR under NHM across pools have not been initiated
- There is no institutional set up for management of HR, hence state specific HR policy should be formed looking at recruitment, selection, training, transfer, incentives, appraisal and increment systems.
- Competency based skill assessment and performance based incentives must be rolled out.
- State should also work towards establishment of separate Public Health Cadre that includes program management as a sub-cadre.

14. Tamil Nadu

A. Availability of HR

- The state has a well-structured Public Health Cadre. For candidates with MBBS, the government meets the cost of education for completing MPH course for two years. Additionally they are provided salary for these two years.
- There is an adequate number of Specialized HR along with Medical Officers and Staff Nurses positions in facilities
- Vacancies were observed for the positions of technicians (lab & OT) along with VHNs. This is adversely impacting primary health care at HSCs and PHCs and needs to be adhered to population norms of 1 VHN over 5000 population.
- There is also inadequate HR at Primary Health Care Facilities i.e. HSCs and PHCs

B. Training & Capacity Building

- ICDS workers are given career progression of becoming VHNs by undergoing ANM training.
- The regional training institutes are well equipped with good infrastructure and adequate manpower to carry out various categories of training. The training center prepares a comprehensive training plan annually. Government is also planning to introduce TMIS
- The health management development institute has skill lab training center which is very well maintained along with proper demo mannequins.
- There are at present 11 ANM training institutes functioning very well with adequate infrastructure and teaching faculty. Only issue is with the hostel facility in namakkal and dedicated bus for field work in Tirunelveli.
- Staff Nurses are given time bound promotion without any training, which needs to be reviewed.
- SBA, NSSK training to be given to staff nurses posted at Medical College Trunelveli and training target of cold chain handlers needs to be met.
- ASHAs should be given preference for admission to ANM training schools.

C. Workforce Management

- The contractual NHM staff is absorbed in to the regular cadre
- There is an excellent functioning grievance redressal mechanism at both state and district level. At state level 70% grievances have been resolved.
- HRMIS is functional in regard to the three Directorates of health departments except capturing details of contractual workforce.
- Both at state and district level there is a facility based and performance assessment as part of monthly review meetings against the fixed targets for both contractual and regular staff.

15. Tripura

A. Availability of HR

- State has rationally deployed accountants between 2-3 PHCs based on workload
- About 45 % of the sanctioned posts are lying vacant and

significant vacancies are there in both regular and contractual cadre.

- Due to irrational deployment the specialist positions such as Gynecologists, anesthetists and pediatricians are concentrated in the DH/SDH.
- The retention of the staff is low due to low salaries, absence of career progression pathways, lack of HR policy and postings and transfers policy.

B. Training & Capacity Building

- TMIS is under progress in the state
- Comprehensive pre-service & in-service plans have not been adequately formulated at the state and district level.
- State training policy needs to be aligned to government guidelines for multiskilling key staff and quality assurance trainings.

C. Workforce Management

- During postgraduate selection, preference is given to those who have served in rural and remote areas.
- There is a provision for reservation for ASHAs in ANM schools.
- There is no public health cadre in the state.
- The state does not have formal HR cell and recruitment of various positions has been pushed to once a year and conducted by the district level. There is no scoring sheet while recruiting candidates for the various positions to assess their knowledge and skills.
- The advertisements for vacancies have limited visibility, as they are usually withdrawn after 7 days, low circulation of newspapers and annual frequency of publishing advertisement
- Performance appraisal system is the basis for contract renewal. There is self as well as assessment by the immediate supervisor.
- The education criteria mentioned in the TORs for various categories needs to be revised to include the required skill set for each job responsibilities.
- There is no centralized HR policy & incentives for deployment and retention of HR.
- HRIS has not been implemented in the state at present. Also gaps have been observed in the data for HR workforce.

16. Uttar Pradesh

A. Availability of HR

- For postings and transfers of regular staff, the criteria is annual appraisal and seniority. Promotions are displayed on state government website except for ANMs and Group D staff.
- There is a shortage of human resources - Medical Officers, Group D staff hence affecting the quality of services being rendered at health facilities

B. Training & Capacity Building

- TMIS (Training Management Information System) is being used by state and districts as well.
- Training of contractual staff is regularly being conducted by NHM.
- Trainings/refresher trainings may be planned and conducted regularly

C. Workforce Management

- Human Resources Information System (HRIS) has been developed and being used effectively
- Contract renewal is subject to skill evaluation where qualifying criteria is 50% and below which contracts are not renewed
- Performance based incentives are being provided to frontline health workers e.g. SBA staff nurse is given Rs.400 per delivery beyond 25 cases per month
- HR policy for contractual staff under NHM is yet to be implemented in the state
- False reporting was observed in many registers being filled by ASHA/ANM/Staff nurse

TOR 6 | COMMUNITY PROCESSES and Convergence

OBJECTIVES

- To review the present status of ASHA program with reference to progress and the quality of training, analysis of ASHA drop-outs, promptness in selecting new ASHA, monthly incentive amounts, payment mechanisms (PFMS and Aadhar linked) and regularity of payments, non-monetary incentives, periodicity of replenishment of Drug Kits, adequacy of equipment kits, quality of home visits and community interaction, with a focus on the marginalized.
- To document the key challenges and constraints faced by the ASHA
- To appraise the progress made under NUHM – with regards to (a) Mapping of vulnerable population; (b) Mapping of slums in target setting for ASHA and MAS and adequacy of targets of ASHA and MAS: (c) Status of ASHA selection and training; (d) Constitution and training of MAS; (e) Level of integration of support mechanisms available under NRHM with NUHM for CP interventions viz- staff, grievance redressal mechanisms, payment process, performance monitoring etc; (f) Assess the challenges faced by the state in implementation of community processes interventions in urban areas.
- To assess the extent of integration and effectiveness of support structures at various levels for VHSNC, ASHA and Community Action for Health (CAH), periodicity of review meetings, mechanism of performance monitoring of ASHA, status and effectiveness of ASHA software for payment or other ICT platforms to improve payments,
- To appraise the constitution/reconstitution and quality of meetings of VHSNC and RKS, and the extent and quality of convergence with PRI, ICDS, Departments of Education, Water & Sanitation and Rural Development. Status of fund flow and utilization of untied funds.
- To analyze the preparedness of ASHA and VHSNC to undertake tasks related to rolling out comprehensive primary health care

National Overview

This year marks the eleventh year of the ASHA programme. ASHAs are in place, in all States except in Goa, rural areas of Puducherry, and the non-tribal areas of Tamil Nadu. ASHAs fulfil a gamut of needs demanded of her by the system and by the community, but require continuous support and handholding. About 8.73 Lakh ASHAs are in position against the target of 9.46 lakh in rural

areas (91%). 34 out of 35 States/ UTs are also implementing ASHA programme, under the National Urban Health Mission (NUHM). A total of 42,769 ASHAs have been selected against the target of 70721 (60% selected) in urban areas.

Progress in the four rounds of Module 6&7 training across the States shows, that the North East States, which were the first to start and complete the Module 6&7 training rounds, from the very beginning, have not made much progress in the last year. The overall achievement in Module 6 & 7 shows that about 87% ASHAs have been trained in Round 1, 82% in Round 2, 60% in Round 3 and 33% in Round 4 of Module 6 &7 Some slowdown in the pace of training coverage can be noticed nationally in comparison with the period ending in June 2015.

Across the States, process of completing the recruitments for ASHA support structures or establishing dedicated ASHA support cadres has not seen any major additions during this period. However vacancies continue to exist, with States not filling in the gaps at block and district levels. States have begun to focus on a more structured strengthening of the support structures. Recently, a renewed focus is being seen in many States on conducting regular reviews of ASHA programme at the state level, and also ensuring review meetings in the districts.

Most States are making payments for ASHA incentives online, except

in few remote areas where bank accessibility is poor.Incentive payment mechanisms have been streamlined and almost all States have started making payments either in cheque or bank transfer mode but delays in payments specifically for incentives linked with activities of NVBDCP, RNTCP and NLEP, are common and remain unresolved. In such areas payments are being made in cash mode in States of Manipur, Meghalaya, Sikkim and UT -Andaman & Nicobar islands. Linking of ASHA accounts with Aadhar cards has also made much progress.

In addition to the performance based incentives linked with various activities, some States have also introduced fixed monthly honorarium for ASHAs in : Sikkim : Rs. 3000 pm; West Bengal- Rs. 1500 pm; Kerala: Rs.1500 pm; Haryana- Rs. 500 pm; and Rajasthan - Rs. 1600 pm: from the ICDS budget or matching the incentives earned by ASHAs as top up in the States of–Chhattisgarh, Karnataka, Meghalaya and Tripura. Progress on instituting mechanisms for grievance redressal has been made but these committees are yet to become effective.

In order to provide additional support to ASHAs, few States have introduced social security schemes to provide range of support to ASHAs, eg – medical and life insurance, educational support to children and pension etc. About ten States support ASHAs through social security measures. Of these, four States i.e, Chhattisgarh, Jharkhand, Kerala and Assam have introduced new schemes designed specifically to cover ASHAs and ASHA facilitators. In remaining six States, States facilitate enrolment of ASHAs in the existing schemes such as NPS – Swamlamban

Yojana, Atal Pension Yojana, Pradahan Mantri Jeevan Jyoti Bima Yojana or any state specific Chief Minister Rajya Bima Yojana.

In order to expand career opportunities for ASHAs, States like Chhattisgarh, Jharkhand, Madhya Pradesh, Uttarakhand, Jammu & Kashmir, Maharashtra, Arunachal Pradesh, Assam, Mizoram, Nagaland and Tripura have made provisions for preferential enrolment of ASHAs in ANM/GNM schools.

Nearly 5 Lakh VHNSCs have been constituted across the country. However, the functionality of VHSNCs varies across States timely fund flow, training of VHSNC members and capacities of ASHAs and ASHA facilitators to take a lead role in VHSNCs. The Rogi Kalyan Samiti guidelines were revised in 2015, and most States are currently undertaken the reconstitution of the committees.

Key findings

Of the 16 States visited during the Tenth Common Review Mission, eight belong to the Non High Focus state category, three to the North-East, one Union Territory and the remaining three to the High Focus States. Of the community processes component, the state of Chandigarh has ASHA in urban areas, and Tamil Nadu has ASHA is selected tribal blocks/pockets. In Himachal the ASHA programme is still at a relatively nascent stage. Village Health, Sanitation and Nutrition Committees (VHSNCs) are however expected to be formed and be made functional across States, as are the Rogi Kalyan Samities (RKS). The Terms of Reference for state teams visiting the States, therefore covered key details of all three components.

Overall the picture that emerges from the state reports is that of a motivated ASHA and acknowledgement among programme managers that the improvement in indicators related to immunization, increased institutional delivery and indeed increased care seeking behaviour is on account of the facilitatory role played by the ASHA. There is also increasing ownership of the ASHA by the health system, and visualization of the ASHA as a key community resource, valued for her facilitatory role. The other two roles, emphasized in design and training content, of activist/ social mobilizer and community care provider are yet to be fully realized. A related overarching finding is the high variability in skills among ASHA related to nutrition, family planning, danger sings in pregnancy, and signs of sickness in new-borns and children. Unsurprisingly there also appears to be a strong positive correlation between the high training frequency and the knowledge and skill levels of the ASHA.

As the following sections demonstrate, the implementation of the programme at district and sub district levels, the manner in which it is supported at state and district levels, the capacity for application of field learning and changing contexts, particularly in non-high focus States, by senior programme mangers requires substantively greater effort. This is needed in order to fully realize, not just the potential of the ASHA, but also of the broader community level mechanisms that encompass the National Health Mission's

(NHM) community platforms for public participatio, the VHSNC and the RKS and the outreach health care components.

Regarding the VHSNC and RKS, the findings demonstrate that progress on both components is slow and irregular, although variable. The slow pace has affected convergence for action on social and environmental determinants on which several health outcomes depend. This is a significant missed opportunity and requires concrete actions.

With regard to the Community processes components in the National Urban Health Mission (NUHM), while the functions of selection and training are picking up speed, clarity in the role and support for the ASHA, including low incentive payments and relatively higher rates of attrition need attention.

1. ASHA Selection and Training

Overall selectionin several States exceeds 90% of the target. However, in Uttar Pradesh, Chandigarh, and Delhi, there is still a shortfall. Intra district shortfalls were noted in Uttar Pradesh, Maharashtra and Andhra Pradesh. In Kerala, a decision was taken despite a significant shortfall, that no new ASHA would be selected, given the widespread availability of Kudumbashree volunteers. However, the report from Uttar Pradesh indicate that the ASHAs are covering populations over 1500 or there are several villages in which ASHA selection is pending, either not having been selected at all or because of drop-out. This is particularly an area of concern, since the existing ASHA have to cover populations of over 3000, which is likely resulting in reduced coverage affecting those living on the margins. As RCH indicators improve, last mile coverage becomes expedient, and thus ASHA selection in marginalized areas is important. In remote geographies like Arunachal, ASHAs cover smaller populations.The implications of population coverages reflected in incentive amounts earned.Thus the UP report which notes high population coverage by some ASHAs, States that, "substantially high amounts of incentive being earned every month by a substantive number of ASHAs warrants that the details of this important trend need to be reviewed". In Arunachal the report notes that the amounts of incentive given low populations allocated tothe ASHA result in small incentive amounts. In all States, urban ASHA selection is underway and yet to reach targets. For those selected, induction training is reported to have begun in all States except Uttar Pradesh. In rural areas, attrition levels were reported to be lower than 2%, except in the case of Tamil Nadu where attrition levels of about 23% are reported and Madhya Pradesh – 10% (in Dindori). Kerala also reports high attrition. Attrition appears to be higher in urban and peri-urban locations due to better opportunities and insufficient incentives.In 2010-11, the competency based modules (Modules 6 and 7 to be covered in four rounds separated by six to eight weeks) were launched. While most States, except Uttar Pradesh, Himachal and Chandigarh, initiated Module 6 and 7 training for ASHA in FY 11-13, completion of training was reported from Tripura, Arunachal Pradesh, Nagaland, and Kerala. Training lags behind significantly in all other States, notably Bihar, Uttar Pradesh, Andhra Pradesh, Jammu &Kashmir, Madhya

Pradesh, and Maharashtra. There is in particular a lag between training rounds, which leads to attrition of skills and knowledge, resulting in poor quality services including counselling by the ASHA. Tripura and Andhra Pradesh report attrition of trainers and in Andhra, reduction in training sites after division of the state, was proffered as a reason for slow progress. Uttar Pradesh and Madhya Pradesh also report a similar problem. In Bihar, the state has not paid the state training agencies, nor selected new district training agencies, as a result of which there is very nearly a standstill of ASHA training. There is also quite a time lag between new ASHAs selection and induction training. This is noted in Delhi, Chandigarh, Uttar Pradesh, and Andhra Pradesh. States such as Tripura and Maharashtra have developed innovative methods such as conducting quizzes to assess knowledge and skills of ASHA periodically. This enables regular refresher training of ASHA. From the reports, it appears that only Tripura has undertaken refresher training for its ASHAs.

2. Support Structures

Structures to support and mentor the ASHA exists in nearly all States. While several States have recruited new staff at district and sub district levels Andhra, Delhi, J &K, Himachal, TN, Chandigarh, and Kerala, use existing staff such as ANMs or District Public Health Nurses. The state report from UP with the largest number of ASHA, acknowledges that having such a structure in place is critical to laying a strong foundation for the ASHA programme. However, vacancies in support staff at all levels were reported except in Uttar Pradesh. Even in States such as Madhya Pradesh, where the support staff are in place, the orientation and understanding of the staff needed strengthening. In Bihar and Jharkhand ASHA facilitators continue to also work as ASHA, despite recommendations from several quarters to the contrary, compromising their functions in both roles. In Uttar Pradesh, which also followed a similar model till recently, the state asked ASHA facilitators to choose between functioning as an ASHA or as an ASHA Facilitator. Most AFs chose to remain as facilitators indicating that they appreciated and recognized the need for effective mentoring of ASHA. Several States also recognize effective partnerships between ASHA and ANMs. This is seen in Andhra, Nagaland, J&K and UP. This improved coordination between the two frontline workers results in better outcomes in respect of outreach services. The J&K and the Uttar Pradesh reports also note effective functioning of the triple AAA platform, indicating convergent planning and action between the Health and ICDS departments. State ASHA mentoring groups, which are an important support mechanism—are active in Uttar Pradesh.

3. Incentives

Most States are now providing both financial and non financial incentives to the ASHA. Payment mechanism have been streamlined, in most States, with a majority of ASHA now having bank accounts. Most States also report reduced payment delays. However, in Andhra Pradesh delays of between one to three months have been reported. PFMS linkage is reported from Madhya Pradesh,

Uttar Pradesh, and through RTGS in J&K. Average monthly incentive amounts ranged from Rs. 2350 in Jharkhand (inclusive of routine and recurring), Rs. 900 in Nagaland, Rs. 1000 in Kerala, plus a state stipend of Rs, 1500, Rs. 1500 to Rs. 2000 in Andhra Pradesh, Rs. 1500 In Tamil Nadu, Rs. 3200 in Tripura including the 33% state provided top-up amount, Rs. 4250 in Anant Nag district of Jammu &Kashmir, Rs. 4000 in Gandhi Nagar, Gujarat, and Rs. 2200 in Navsari, Rs. 2224 in Madhya Pradesh, and Rs. 1358 in Uttar Pradesh. Routine and Recurring incentives have been reported to be provided in Maharashtra, Himachal Pradesh, J&K, UP and AP. UP has provided mobile phones to all its ASHAs, mobile talk time to ASHAs in Upper Siang, J& K, ASHA awards in Madhya Pradesh and Uttar Pradesh, and ASHA uniforms in MP and J&K. States such as Maharashtra, Kerala, Jharkhand, Bihar and Madhya Pradesh have provided insurance cover to the ASHA as part of social security schemes. States such as Kerala, Bihar, Tripura, Maharashtra and Jharkhand have made provision for preferential selection of ASHA in ANM/GNM training schools. In some States, ASHA are also being promoted to the post of an Asha facilitator or Block Mobilizer (UP).

4. Grievance Redressal Mechanism

Grievance redressal mechanisms are reported from Kerala, Andhra, MP, Maharashtra, Jharkhand, Delhi, and UP. However, systems for feedback and action are yet to be developed in the States visited.

5. Drug and Equipment Kit

Most Statereports indicate problems with availability and replenishment of drug and equipment kits. Andhra, Delhi, Gujarat, J&K, Nagaland, and Tripura. In Bihar, while replenishment is expected to be from the sub centre, ASHA did not have any drug supply at the time of the visit. IFA had not been provided for the last two years to ASHA and ANM in Bihar. No drug or equipment kits were available with ASHA in Chandigarh, Himachal Pradesh, Nagpur district of Maharashtra, Kerala and Tamil Nadu. Short supply of Nischay kit was noted in UP. This is reflective of the implementers' perception of the role of the ASHA, even though anecdotal evidence and evaluation findings from the field indicate active use of basic drugs and diagnostic kits when the ASHA has a supply.

6. Functions and Functionality

In most States, reports indicate that there is a need to improve the quality of skills of the ASHA. These particularly relate to nutrition, counselling for family planning, recognition of danger signs of pregnancy, understanding of early recognition of first contact care for sick new-borns and children. In Nagaland, ASHA reportedly support home deliveries. The Maharashtra report highlights, using the example of the ASHAs role in promoting family planning methods that ASHAs tend to promote methods that are advocated by service providers and programme managers, but are not oriented to issues of reprdcutive rights and choice This is likely to be the consequence not only of the legacy effect in the larger family planning method of focusing on selected family planning methods, but may also be due to the fact that the ASHA training itself tends to focus less on the mobilizer/activist role, and

emphasizes the facilitator role. In high focus States and non high focus States alike the predominant emphasis is on RCH. However, the Kerala report notes that ASHAs are involved in raising awareness about Non communicable diseases and serving as a member of the palliative care team. Her role in providing follow up care in these contexts is limited for want of adequate knowledge and skills, a point that is highlighted in the report. Home based newborn care is reported from all States, except Chandigarh and Kerala. Although Idukki has pockets of high neonatal mortality, ASHAs are neither trained nor equipped to undertake HBNC. One issue that has been raised from Arunachal is that older ASHAs are unable to perform the village and house visit functions effectively. Under NUHM, some States are considering outsourcing of PHC functions. The Andhra Pradesh report indicates that neither the state nor the outsourced partner has considered the role of outreach and frontline workers such as the ANM or ASHA in the package of services to be provided.

7. Performance Monitoring

The reports from States on this component are mixed. Some reports state that such performance monitoring is being undertaken, but ASHA facilitators' knowledge and experience in using the tool seemed low. This was seen in Bihar, Madhya Pradesh, while in Jharkhand, even though the ASHA facilitators were actively involved In other States such as Kerala, the quantum of incentive is used as an indicator of performance, regardless of population coverage or disease profile.

Status and Functioning of Village Health Sanitation Nutrition Committee (VHSNC), Mahila Arogya Samiti and Rogi Kalyan Samities

i. Reports regarding the functionality of VHSNCs varies across all 16 States visited, and take into account VSHNC constitution as per guidelines, timely fund flow and fund utilization, orientation of VHSNC members regarding their roles and responsibilities and involvement of ASHAs and PRIs in VHSNCs. Overall the impression from the reports is that functioning of VHSNC do not reflect the vision of VHSNCs as envisaged under the NHM.

ii. Most States have constituted over 95% of VHSNCs against their state targets. These include Arunachal Pradesh, Bihar, Chandigarh, Gujarat, Jharkhand, Jammu & Kashmir, Kerala, Maharashtra, Tamil Nadu and Tripura. Among the remaining States, Andhra Pradesh, Arunachal Pradesh and Uttar Pradesh have constituted about 76%, 84% and 87% VHSNCs respectively. In contrast, Himachal Pradesh has been able to constitute only 5% VHSNCs i.e, 400 against the target of 8000 VHSNCs. The Village Health Committees formed as part of communitization in Nagaland before the launch of NRHM have been co-opted as VHSNCs but the committees, do not function as per the principles of VHSNCs.

iii. Among the States visited, VHSNCs have been constituted at revenue village level in Andhra Pradesh, Arunachal Pradesh, Chandigarh, Gujarat, Jharkhand, Maharashtra, Madhya Pradesh, Nagaland and Tamil Nadu; at ward level in Kerala (known as Ward Health Sanitation and Nutrition Committees – WHSNC); and at Gram Panchayat level in Bihar, Jammu and Kashmir, Himachal Pradesh, Tripura and Uttar Pradesh.

iv. With regard to the membership of VHSNCs, the guidelines recommend that ASHAs should be made member secretary of VHSNCs. However, this finding has been highlighted only in the Jharkhand report. State reports from AP, HP, J &K, Kerala and MP indicate that ASHAs act as joint signatories for VHSNC accounts. The ANM has been reported to be the member secretary of VHSNCs in AP, HP and Kerala. ANMs continue to act as member secretary and joint signatory

in the States of Bihar, Tripura and UP.

v. Reconstitution of VHSNCs was reported to be underway in Jharkhand and Chandigarh. Reports from Chandigarh, HP, MP and Kerala, have highlighted that over 50% of the VHSNC members were women. In Madhya Pradesh, the village level committees for various sectors have been merged. Thus the committee has representation of general community, service users, PRI representatives and ICDS staff. Membership of VHSNCs in UP was limited to ex-officio members like ASHA, ANM, AWW and teachers with no community member representation. Lack of conscious efforts to ensure adequate representation of marginalized and service users were reported from AP and Chandigarh.

vi. Lack of effort and commitment to build capacity of VHSNCs was observed across all States except Chandigarh, Jharkhand and Tripura where training of VHSNC members has be n undertaken during the last one year. In the remaining States, training of new VHSNC members has not been prioritized. This was evident in state findings, Eg- In Bihar, Maharashtra, Gujarat and Tamilnadu, where no training of VHSNC members has been conducted over last 2-4 years and slow pace of training of VHSNC members was reported from MP where majority of VHSNC members have not received any training. In Himachal Pradesh and Kerala new VHSNC members have not been trained. Level of awareness among the members and their competencies in organising the affairs of VHSNC was identified as a weakness across most States (except Chandigarh).

vii. Issues related to VHSNC untied funds have been largely unresolved over the last few years in most States. The major challenges include delay in release of untied fund release, utilization and management of untied funds. State reports of AP, Arunachal Pradesh and MP reflect that untied fund for the current financial year is yet to be released while amount of Rs. 6906/- and Rs. 7500/- was released in Arunachal Pradesh and Tamil Nadu respectively. This could be linked to poor utilization of untied funds, which was noted in Jharkhand, Madhya Pradesh and Andhra Pradesh. Timely fund flow was observed in Gujarat, HP, Jharkhand and Kerala. High levels of convergence and strong panchayat system has led to pooling of resources of funds in Kerala from NHM (10,000), State Suchithra Mission (Rs. 10000) and Local Self Government Department(Rs. 5000), which amounts to Rs. 25,000 per year for WHSNCs.

viii. Untied funds are largely being used for activities related to water and sanitation, purchasing of drugs and equipment for AWC and SHCs, registers for VHSNCs etc and not as envisioned at the time of design of NRHM. Directives for utilization of untied funds are being issued in Jharkhand and MP from the district/ state level undermining the spirit of VHSNCs. In Kerala the untied fund is also utilized for paying incentive to ASHAs for household visits.

ix. Most States report that regular meetings are not being undertaken except in Tripura and Kerala.

Mahila Arogya Samiti (MAS)

i. MAS have been formed in Andhra Pradesh, Gujarat, Maharashtra, Jammu and Kashmir (Anantnag district), Jharkhand, Nagaland (except Mon district), Tamil Nadu (Chennai Corporation areas) and Tripura while it is underway in Delhi, Bihar, Madhya Pradesh and Jammu and Kashmir (except Anantnag). No MAS has been formed till date in Chandigarh, Kerala, Uttar Pradesh, Nagaland (Mon district), Tamil Nadu (except Chennai Corporation areas).

ii. In Andhra Pradesh, MAS formation in Kadapa district is facilitated by an NGO and in Krishna district by MEPMA. Similarly, in Maharashtra, SNEHA, a NGO has been given responsibility for forming and implementing MAS. In Bihar, NUHM is in working in coordination with National Urban Livelihood Mission for the formation of MAS, however, no MAS has been formed yet. In Kerala, district level officials informed that state planned to co-opt the existing Kudumbashree groups as MAS but no formal guidance/communication from the state is issued till date. MAS in Chandigarh has not been formed due to absence of committed people to work as MAS members despite of intense efforts taken by the UT in forming MAS. Hence, ASHAs were identified in urban slums for community mobilization.

iii. MAS formation in Andhra Pradesh is not in accordance to the guidelines as the chairperson and member secretary were both ASHAs. In Tuensang district, Nagaland it was reported that the ASHA, Aanganwadi worker and mothers from the ward constitute MAS. The member with higher educational qualifications is appointed the chairperson.

iv. MAS has received training in Arunachal Pradesh according to the guidelines. In Gujarat, training of MAS is to be facilitated by Chetna. Trainign of MAS is compete in Jharkhand and Tripura. No training and capacity building activities have been conducted for MAS in Jammu and Kashmir.

v. MAS accounts have opened in Gujarat, Jammu and Kashmir Nagaland, and Tripura. The bank account of MAS and fund transfer has not initiated in Andhra Pradesh and Madhya Pradesh.

Rogi Kalyan Samitis

i. RKS have been constituted in all States but the level of functionality was different across States on account of limited or no capacity building, delay in fund release and limited involvement of PRI representatives.

ii. No state reports discussed the constitution of RKS except in Andhra Pradesh, Arunachal Pradesh, Jharkhand and Tamil Nadu. Of these States, the RKS are in synergy with the guidelines in Arunachal Pradesh and Tamil Nadu. In AP, state has constituted Hospital Development Society (HDS) with no separate executive and governing body and membership is not in accordance with guidelines. The process of reconstitution of RKS is underway in Jharkhand to enable greater representation of PRI members.

iii. Meetings of RKS were reported to be irregular across all States, as they are organized only in case of specific requirement and not on a routine basis. Poor record maintenance of RKS was observed in Arunachal Pradesh, Bihar, Himachal Pradesh and Kerala.

iv. Delay in release of RKS funds was reported from States-AP, Jammu and Kashmir, Kerala, Madhya Pradesh and Tripura.

v. In Kerala, the main source of funding is NHM untied funds and additional grants are received from local self-government. In Delhi, RKS members have been able to

mobilize resources for GTB hospital. However, report highlights that the untied fund received from NHM has largely been unspent since 2012.

vi. The reports indicate that the RKS funds are mostly being used for maintenance activities in most States which could be due to lack of orientation about the objectives and scope of RKS to take initiatives for improving quality of services and patient grievance redressal. Only in Delhi, the fund is being utilized to set helps desks for patients and electric cart for patient's movement within the hospital premises.

vii. Non-existence of grievance redressal system and no provision of providing feedback by the patients was reported in Arunachal Pradesh, Bihar, Himachal Pradesh and Kerala. In Jharkhand and Delhi measures have been taken to seek feedback and complaints from patients.

Convergence

i. Mechanisms to establish convergence with departments like ICDS, SHGs, Water and sanitation and PRI are weak across most States except in AP, Chandigarh, Kerala and Gujarat. In AP, initiatives such as Mana Bhavitha and Anna Amrutha Hastam provide good convergence platform at GP and PHC level. In Kerala, strong convergence between NHM, Local Self Government (LSG) and other line departments was reported as part of Comprehensive Health Plan (CHP). This has resulted to huge amount being earmarked by LSG for health care improvement to be carried out through different health facilities (DH, CHC, PHC, SC).

Community Action For Health

i. In Arunachal Pradesh(one district - East Siang), Kerala, Madhya Pradesh and Tripura (one district -Gomati), Community Action for Health programme has recently been rolled-out. Tripura plans to undertake scaling of CAH in the near future.

ii. In Kerala, Arogya Keralam Puraskaram has been awarded to best performing PRIs under CAH which has infused a sense of competition among PRIs.

iii. Poor utilization under Community action for Health was reported from Gujarat since 3 years despite support from Advisory Group on Community Action (AGCA). This has led to lapse of funds in Gujarat. Madhya Pradesh has implemented Community Action for Health programme started in 7 districts, however CAH could not be observed in the two visited districts.

Recommendations

1. Implementation experiences of the past decade, require that the community processes component not only in urban areas but also in rural areas, now needs a design modification, to enable integrating it within comprehensive primary health care. This will provide an additional mooring for the programme, enabling the ASHA to function as a member of the frontline worker team, and facilitate the implementation of the promotive, preventive, rehabilitative components of primary health care.

2. Given the experience of the past several years, States should now undertake a mapping exercise to assess gaps and prioritize selection only in such areas where there are vulnerable and marginalized populations. States should also assess population coverage of the ASHA and ensure that there are no missed out households.

3. Non-high focus States now need to factor in the changing epidemiologic and disease patterns and project newer roles for ASHA. One direction in which this can be undertaken is to build on the comprehensive primary health are rollout announced by the MOHFW. ASHA should be considered a part of the frontline worker team.

4. ASHA training in Module 6 and 7 needs to be expedited so that ASHA may be equipped for other roles. This is also a pre- requisite for Level 1 certification.

5. Given that several indicators related to RCH have improved, States now need to realign their incentive structures and correlate them with the revised roles of the ASHA. This will require extensive consultations with district and sub district stakeholders including, most importantly the ASHAs themselves.

6. States need to expedite selection and training in urban areas under the NUHM. The NUHM offers an opportunity to immediately link the ASHAs as members of the primary health care team. This will require a review of roles and incentives.

7. For VHSNC and RKS, a key step to ensuring functionality is to build the capacity of the members and create systematic training structures as was done in the case of the ASHAs. The active engagement of Panchayat Raj Institutions is required and States should consider leveraging the capacity building funds awarded to Gram panchayats under the 14th Finance Commission.

8. The RKS requires to be strengthened as an accountability structure for quality of care. The current push for certification and accreditation under the Quality assurance framework, should engage proactively with RKS members to leverage mutual objectives and to strengthen the RKS as a mechanism to sustain the quality standards.

9. Given the myriad concerns with release of untied funds and the state findings of the multiple yet seemingly ineffective use to which funds are put, the process for release of untied funds for VHSNC, MAS and RKS need to be reviewed and streamlined. States should consider leveraging GP funds as Kerala has done.

State Findings

1. Andhra Pradesh

i. Average incentive received by ASHA is between the range of Rs. 1,500-2,000 and ASHAs are also getting routine and recurrent incentives.

ii. Good team work is visible between ANM and ASHAs for organizing service delivery for VHND and screening of MMHC (Master Maternal Health Check-up for women over 35 years of age).

iii. Ownership of the ASHA programme, VHSNC and RKS by the health system is poor and support mechanisms for CP interventions need strengthening.

iv. 24.3% of tribal villages have no ASHAs and have been assigned to the ASHAs in the neighbouring village which affect the access of services for residents.

v. No stock outs of HBNC and drug kits are reported but payment delays of 1-3 months are common in both urban and rural areas. RNTCP incentives have not been paid since 2014.

vi. State has recently identified MPHS (F) based at PHC as ASHA Facilitators, who on account of constraints like age, other responsibilities and high density are not able to provide effective support on the job mentoring support to ASHAs. Performance monitoring reports are being generated by MPHS (F) but the quality of reports is not satisfactory and lacks regular review and analysis.

vii. Functioning of programme at block and district level is affected by absence of structured review, regular training, mobility and internet support.

viii. Grievance Redressal Committees have been constituted but are not functional.

ix. VHSNCs have not been re constituted as per the guidelines. Lack of training and regular handholding was noted for VHSNCs and RKS.

At state and district level there is no designated nodal officer managing the VHSNC and RKS.

x. Initiatives such as Mana Bhavitha (erstwhile MAARPU) and Anna amrutha Hastam provide good convergence platform at GP and PHC level.

xi. Similar membership of Mana Bhavitha and VHSNC lead to confusion at village level where monthly meeting of Mana Bhavita is considered equivalent to VHSNC meetings. ASHAs also perceived that monthly incentive of Rs. 150 is for Mana Bhavita (which has no provision for incentive).

xii. State has created Hospital Development Society (HDS) at facility level with no separate executive and governing body. Membership is not in accordance with the National Guidelines. HDS funds are currently used as a maintenance fund due to lack of clarity.

xiii. PRI representation in HDS is poor; while in VHNSC despite adequate representation participation of PRI is poor in Kadapa district.

xiv. Recent decision of managing UPHCs on PPP mode has created anxiety due to lack of clarity among ASHAs and ANMs about their working arrangements. Officials from Apollo in Kadapa admitted that they are not sure about continuity of outreach sessions and linkages with ASHAs.

xv. MAS formation (facilitated by NGO in Kadapa and by MEPMA in Krishna) is not in accordance with guidelines, and opening of bank account and fund transfer has not yet started.

2. Arunachal Pradesh

i. ASHA selection in state is 99% under NRHM.

ii. 88 ASHAs dropped out in year 2015-16 in the state, new ASHAs were selected and received induction training

iii. 96% of ASHA have completed the training till Round four of Module 6 & 7 in both the districts visited.

iv. Poor handholding of ASHA and ASHA Facilitator was noticed in the field. Orientation of ASHA support structure and their mobility in field is an issue of concern.

v. Supply of drugs and kits is irregular and high skill attrition in HBNC and other activities was noticed.

vi. It is observed that ASHAs are not well respected in the community, since a large proportion of community seeks services on their own.

vii. Irregularity in incentive payment was observed, especially for malaria, tubectomy and measles in East Siang district.

viii. Lower literacy levels among some ASHAs and older ASHA unable to undertake regular activities are constraint to career opportunities.

ix. There are 3772 functional VHSNCs in the state formed at village level/sub-centre level. PRI participation in VHSNC meetings is poor but controls financial decisions. The level of documentation of VHSNC meetings is variable.

x. The RKS is formed and exists according to guidelines at every health facility. Meetings are irregular and maintenance of records is not updated. No meeting of RKS at district health facility of Upper Siang was held. RKS meetings when conducted are carried out in an informal way without any intimation to members.

xi. Grievance redressal mechanisms are largely missing. Even where present, members lack orientation to guidelines.

xii. Only one district i.e. East Siang has Community Action for Health (CAH) committee.

xiii. ASHA work as a link between the villagers and the NGO. CAH members are already

trained at district and state level.

xiv. Intersectoral convergence is poor.

3. Bihar

i. State has 91% of ASHAs selected against the target of 93,867 under NRHM, and 66% selection of Urban ASHAs against the target of 391. Since last two years no new ASHA has been selected in Siwan district.

ii. Since last one year, no trainings have been conducted for ASHAs under NRHM. Under NUHM, training of state trainers has been done, but there is a slow pace of mapping of slums seen in urban areas.

iii. State shows a slow progress in terms of training of ASHAs, 91% ASHAs are trained it Round 1, 78% in Round 2, 65% in Round 3 and only 8 % in Round 4. In last one year, no training have been conducted.

iv. Training of ASHAs was managed by NGOs at state and district level. At state level, MOUs were signed with four agencies (PHRN, Janani, Caritas India and PFI), out of which PFI opted out in April 2014 and MOUs are not renewed for the other three agencies as well. Payments for all agencies are still pending and needs attention.

v. At district level, the state's MoUs with 14 NGOs to serve as district training agency has expired and no new MoU have been signed.

vi. 98% of ASHAs in state have bank accounts and payment is now done through PFMS.

vii. State has not implemented routine and recurrent incentives for all components yet. For JSY payments, part of incentive is also linked with IFA consumption during ANC period, but IFA is not available in state for last two years.

viii. Some of the ASHAs reported getting lumpsum amount of Rs. 500-700 in last month. ASHAs are acting as DOTS provider but did not receive any payment since 2014.

ix. Replenishment of drugs is irregular in both the districts. In state, only 89% ASHAs have received HBNC kits. Availability of HBNC kit varies amongst ASHAs; few ASHAs have purchased thermometers on their own.

x. State has set up support structures at all four levels. However, there are large number of vacancies and this affect the quality of handholding support to ASHA. Supportive supervision visits are not being done due to insufficient mobility support. High attrition rate among the support staff is seen in the state.

xi. 87% of ASHA facilitators have been selected in state against the target of 4,964. Clarity on performance monitoring system and supervisory roles of AF is poor in districts.

xii. Grievance redressal mechanism is not functional in state.

xiii. State has 100 % formation of VHSNCs at Gram panchayat level with bank accounts. There is no progress in VHSNC training since July 2014. Functionality of VHSNC is reported low in Siwan district. Involvement of PRI is poor in VHSNC and RKS. RKS funds are utilized for purchasing CCTV cameras and other expenses.

xiv. ASHA has good knowledge on maternal health and family planning, but training needs to be improved substantially for child health and new born care. Slow pace of training and lack of refresher training is leading to skill attrition of ASHA.

xv. In West Champaran, some ASHAs are covering population more than 2,500.

4. Chandigarh

i. 50 ASHAs were recruited in the U.T. and currently there are only 78% in place.

ii. For the recruited ASHAs, eight-day induction training was completed in 2015, and

trainings for Module 6 & 7 are planned in December 2016.

iii. Incentives for antenatal care and institutional delivery are approved only for JSY beneficiaries in Chandigarh, so the U.T. finds it difficult to retain ASHAs due to lack of incentives for them.

iv. ASHA Payments are made on a quarterly basis. Chandigarh is streamlining the process of payments.

v. The public health cell of SPMU acts as a support structure for overall management, including ASHAs and VHSNCs for both urban and rural areas.

vi. No formal systems of grievance redressal mechanism are established in the UT.

vii. No mechanisms for non-monetary incentives or career opportunities for ASHA are in place.

viii. RKS is registered and GB and EC are formed for all RKSs. There was no financial audit conducted for the RKS.

5. Delhi

i. The state has 89.25% of ASHAs in place and are present in the urban slums and underserved areas. It was observed that there is a need to map the uncovered areas and revise the targets for ASHA in the district Shahdara.

ii. The state has ASHA support mechanism, integrated in the health delivery system. This has increased cooperation between ASHAs, ANM and Medical Officers and also increased acceptance of ASHA in the community.

iii. Grievance redressal mechanism is in place and complaints from ASHAs are resolved by the district ASHA mentoring group or the ASHA nodal units on a regular basis.

iv. ASHAs are actively engaged in community action through community meetings. In Anvan Vihar Jhuggi Jhonpri, ASHA motivated community to construct toilets in their homes; and now other families of Jhuggi also have started constructing toilets.

v. ASHA diaries, survey registers and training manuals are not available and photocopies are used instead.

vi. Performance monitoring and incentives of ASHAs are done through a single software system. In moving to PFMS, the state is facing a challenge, as some of the ASHA incentives for ASHA are not listed in the PFMS. The process of incentive approval in the state takes more than 15 days. ASHAs are not aware of incentives from DOTS programme.

vii. ASHA district coordinators are not involved in RKS, MAS, and CAH.

viii. The State ToT on MAS for District ASHA Coordinators is complete and the state has initiated mobilising women for the formation of MAS.

ix. RKSs require strengthening through orientation and better involvement of non-official members.

x. RKSs are not utilising the funds available for them. The GTB hospital had received Rs. 5 lakh in 2012 but returned Rs. 4.50 lakhs back to the DSHM in March 2015.

xi. Jan Swasthya Samitis (JSS) under the District RKS for the PUHCs and dispensaries are constituted by the district and submitted to the state for approval. The district is awaiting approval on JSS from the state.

6. Gujarat

i. The state does not have adequate ASHA support structure at the block and the district level. At the State level, Programme Officer ASHA is not having access to the financial reports and expenditures. The Programme Officer does not have an overall view of VHSNC, RKS and CAH interventions.

ii. There is no documented Grievance redressal mechanism in place.

iii. There are no major plan for career opportunities and social security mechanisms for ASHA in the State. At some places, ASHAs are using VHSNC untied fund to buy uniform as it is not provided by the state.

iv. VHSNC members' names and telephone numbers are displayed at all the sub centres. This provides recognition to the member in the village and act as a positive boost for being accountable.

v. VHSNC members are not aware of their roles and responsibilities, and their training is due for last four years. VHSNC meeting registers are not maintained properly.

vi. RKSs are registered and proper records of Funds utilisation are available, but PRI and community participation is low.

vii. Poor utilisation of fund is seen under CAH. Funds have lapsed for the last three years irrespective of the support from Advisory Group on Community Action (AGCA).

viii. Formation of State Advisory Group on Community Action (SAGCA) is still pending in the State.

7. Himachal Pradesh

i. ASHA work in close coordination with ANM (FHW), and are seen by community as a resource with close links with the health system.

ii. Weighing scale and pregnancy kits have not been provided to ASHAs. Availability of thermometer and medicines was found to be poor because of procurement delays

iii. Functionality of ASHAs for HBNC is limited to counselling on breast feeding and care to be taken for a new-born.

iv. State has selected District Programme Officers for ASHA programme and ANMs mentors the ASHAs at sector level. However, no training of support staff has been conducted regarding supportive supervision

v. Rest rooms for ASHAs have not been created at any level.

vi. Only 5% of VHSNCs have been constituted as per the National Guidelines; ANM is the member secretary of VHSNCs and ASHAs are the members of VHSNC.

vii. RKS has been formed in all facilities in Mandi district but no samitis have been constituted in Solan district. In Mandi District, the RKS meetings were found to be regular but record maintenance for RKS needs to be improved.

8. Jammu & Kashmir

i. State has 98% of ASHAs selected against their target.

ii. The pace of ASHA training is slow as only round-2 of module 6 & 7 has been completed in both the districts.

iii. Existing staff is functional as ASHA support system, i.e, Community Health Officers (CHOs) or Health Educators as Block ASHA Coordinator and District ASHA Coordinator and ANMs are designated as ASHA facilitators across the state. However Supportive supervision is poor in the state.

iv. Performance Monitoring is not being analysed and used to improve the knowledge and skill of the ASHAs.

v. Payment of ASHA incentives are through RTGS. Average monthly incentive reported in Anantnag district ranges from Rs. 3500-5000 including routine and recurring activities. In Ramban, ASHAs are not getting the complete amount of routine and recurring activities incentive.

vi. Replenishment of drugs is regular but availability of IFA tablets varies across the districts.

vii. Supply of HBNC kits is not regular and uniform in all the districts.

viii. VHSNCs are formed at Gram Panchayat level and are yet to be reconstituted as per the revised guidelines; ASHAs are signatories of the VHSNC account.

ix. VHSNC Meetings are held regularly and meeting minutes and action points are documented properly.

x. 672 RKS have formed across the state and Meetings are held regularly.

xi. AAA provides a good platform for convergence mechanism through an effective coordination.

9. Jharkhand

i. Sahiyas are knowledgeable and committed to their work and form an effective link between the health system and the community.

ii. State needs to revise the target for sahiya's selection, as current target is based on Census-2001, thus leaving 10-15% villages/hamlets uncovered by any Sahiya.

iii. 94% of total sahiyas are trained up to Round three and Round four still being underway. Meanwhile state has conducted refresher training for its 80% Sahiyas and 2779 ANMs.

iv. Sahiyas are measuring BP and HB as a part of ANC care during VHND. They have not received a formal training for this but have learnt these skills on the job by the ANM.

v. The performance monitoring is done on a regular basis; however, the feedback mechanism is not satisfactory. Sahiya Sathi have a poor understanding of the monitoring indicators.

vi. Sahiyas from Mahagama block of Godda district heave not received any Routine and Recurring incentive till date.

vii. Integration within the support structures of NRHM and NUHM with respect to Community Processes is reported good in the state.

viii. Mechanism of replenishment of drugs is not appropriate and uniform.

ix. State has made it mandatory for Sahiyas to escort pregnant women to institution for JSY incentive.

x. Sahiya Sathis continue to function as Sahiyas for their allocated population impeding their role of a facilitator.

xi. Grievance redressal system is functional only in 14 districts of the state.

xii. Sahiya Help Desks are functional in all 24 districts of the state.

xiii. Sahiya rest rooms are available in 24 districts at DH level and in few FRUs/CHCs of the state.

xiv. State has created a corpus fund which provides an accidental cover to Sahiyas and assist them financially in case of disability and death in an accident.

xv. VHSNCs have been reconstituted in the state but training is yet to be conducted. About 50% of VHSNCs have a woman elected member of GP as its member and chairperson. Members are not participating in VHND, VHP and community participations as of now.

xvi. VHSNC Fund utilization is not as per the guidelines and needs more clarity.

xvii. RKS is being reconstituted across the state. State has involved PRI representatives in RKS and DHS.

xviii. Health promotion through Participatory Learning and Action has been implemented in 6 blocks in state.

xix. Community Based Monitoring activities are undertaken in all the 24 districts with coverage of 137 blocks (6 blocks in each district) and 6850 villages (50 villages in block).

xx. Convergence at the village level is effective; however, it needs strengthening at the block level.

10. Kerala

i. A high rate of drop out of ASHA is found in the state, reason being less monthly income through incentives and availability of other better income opportunities.

ii. ASHA selections are done through interviews and community involvement was not evident in the selection process.

iii. JPHN supports/mentors ASHAs, but their quality of work is getting compromised as they are not trained in modules.

iv. ASHAs are covered under a social security scheme namely ASHA Kiranam which gives them an accidental cover up to Rs. 2 Lakh, depending on the percentage of disablement.

v. The state has listed around 20 different sources of ASHA incentives including all vertical programs under NHM. ASHAs are providing certain NCD services and palliative care services but are not incentivized. The state needs to plan context specific incentives for ASHA for the services they provide.

vi. A robust mechanism of grievance redressal is available in the state, but records show that very few complaints are lodged.

vii. RKS grants are received only from local self-government. RKS meetings are irregular and need based. There is no proper record maintenance and feedback mechanism.

viii. State has implemented Kerala model of decentralized, three tier, Comprehensive Health Plan (CHP), started in 2011-12. CHP is a joint initiative of NHM, Local Self Government (LSG) and other line departments.

11. Madhya Pradesh

i. ASHA selection in state is 94% against the target of 62,853 under NRHM, and 98% against the target of 4,200 under NUHM. In Dindroi district, 100% selection of ASHA (NRHM) has been done.

ii. Dindroi district does not have any ASHA selected under NUHM, while Ratlam had 100% Urban ASHAs selected, out of which 21% have dropped out till date

iii. Dropout seen at state level is minimal i.e. 2%, with the main reasons being career progression, non-functionality and migration.

iv. ASHA software is functional in state and a database of all ASHAs is created at district and state level. The software is linked with PFMS for payments of ASHA incentive.

v. Average incentive earned by ASHAs observed during field visit ranges from Rs 1,500 to Rs 2,500 per month.

vi. Training of ASHAs shows a slow progress and only 24% ASHAs are trained at state level in all rounds of module 6 & 7. In Ratlam district, only 8% ASHAs are trained in all rounds. Also in the same district, 42 newly recruited ASHAs are working without any formal training.

vii. State has also trained ANMs and LHVs in module 6 & 7 to provide support to ASHA.

viii. State has good ASHA support system. There is 1 ASHA Sahyogini (AS) for 16 ASHAs in field, and around 95% ASHA sahyoginis are in place.

ix. Monitoring and supportive supervisory mechanism needs strengthening.

x. Non-monetary incentives are provided to ASHAs for motivation. ASHA awards are given twice a year. ASHA is also covered under insurance scheme where 81% of ASHAs and 99% of AS are enrolled.

xi. Gram Arogya Kendra (GAK) are established at all AWC in the state. There are 48,957 GAKs in the state.

xii. Formation of MAS is not complete in Ratlam, and accounts are not yet opened across the district.

xiii. Regular replenishment of drug kit and supply is done by AS, however the quality of equipment is a matter of concern, for eg. Weighing machines are not functional

xiv. Grievance redressal mechanism is functional at district and block level and MGCA committees are established at various levels.

xv. There are 45 rest rooms for ASHA in state, and they are only at district level. However, temporary rest rooms were available in two blocks of Dindroi district. In Ratlam, ASHA rest room is being used as a part of maternity ward due to space constraints as a part of building collapsed.

xvi. Intensive CAH in started in seven districts of the state.

xvii. VHSNCs are reconstituted in the state as per the guidelines. Minutes for all meetings are recorded and available with ASHA. All members are not trained yet and the pace of training is also slow. In current year, VHSNCs have not received the funds, due to underutilization and non-submission of UC for last year.

xviii. Functionality of RKS is compromised in the districts.

xix. Convergence within the departments is seen but it is not utilized adequately by the department of health.

xx. District level focus on review of ASHA, VHSNC and RKS is poor

12. Maharashtra

i. ASHAs have become integral part of public health system which strengthen the link between community and health system. ASHAs are motivated and well qualified and working efficiently.

ii. Slow progress is noted in urban areas with 60% selection against the target of 10,214.

iii. State is giving preference to ASHAs to fill vacant positions of ASHA facilitators as an opportunity for career advancement. Enrolment of ASHAs in ANM/GNM courses is facilitated and so far, 6 ASHAs have been selected for ANM course and 2 for GNM course.

iv. ASHA payments are linked with PFMS and Aadhar and are done on a monthly basis but delay in payment of incentives for NVBDCP was reported in Nagpur.

v. ASHAs have been included in Prime Minister Accidental Insurance Scheme.

vi. State has introduced a recent initiative to assess ASHA's knowledge for HBNC on a monthly basis through structured questionnaires to ensure that ASHAs keep updating themselves. In Nagpur district ASHAs are well qualified, trained up to 7th module and had satisfactory knowledge about various programmes.

vii. Performance of ASHAs is measured (on the basis of 48 indicators) on the basis of incentives earned through software since 2012.

viii. All VHSNC are constituted at revenue village level and 3 members are trained from each VHSNC.

ix. Grievance redressal committees are functional at district and block level with regular monthly meeting. ASHA use the 104 E-complaint for registering complaints.

x. ASHA drug kits have not been supplied while HBNC kits have been provided to only 500 out of 1680 ASHAs in Nagpur. In Nashik district, ASHAs bags largely contain HBNC related equipment and supplies, while other supplies were not regularly present. Oral pills, and Nishchay kits, emergency contraceptive pills and Iron tablets were not available with most ASHAs.

xi. ASHAs are yet to be selected in urban areas of Nashik by co-opting the existing link workers as urban ASHAs.

xii. State has entered in MOU with SNEHA, to support constitution and training of

MAS. So far, 21.77% of MAS has been formed against the target of 9393.

13. Nagaland

i. Major activities undertaken by ASHAs include house listing, assessing need for services for women and children, assist mothers in home deliveries and participate in VHNDs, however role of ASHAs are limited in counselling, referral, identification of danger signs, identifying SAM children.

ii. A low knowledge level in ASHAs was observed, indicating a need for refresher training. A possible reason for difficulty in attaining a common level of knowledge also stems from the fact that there is variability in the qualification of ASHAs. For instance, in Tuensang district the qualification of ASHAs varied from 2nd to 11th standard.

iii. Most of the ASHAs have drug kits, but its replenishment is irregular.

iv. In Mon, ASHAs payments are being transferred directly to their bank accounts, but in Tuensang JSY payments are still being done in cash. Although routine and recurring incentive is already in place, most of the ASHAs were getting incentives between Rs. 800-1000 in Tuensang.

v. Convergence between health and nutrition department was poor.

vi. Almost none of the health facilities have ASHA help desks or rest rooms for ASHAs.

vii. A major factor aiding ASHA retention is the respect that they get from Village councils and populations in general. In some instances, the Chairperson of the VHSNC mentions names of the ASHA in village meetings and gives her credit for improvement of health in the village.

viii. Composition of the VHSNCs is not as per the guidelines, and its meetings are irregular and vary across the state.

ix. 98 MAS formed. Each ward has one MAS and each MAS has maximum 20 members.

14. Tamil Nadu

i. State has ASHA only in tribal and inaccessible areas. Two main reasons of the state not feeling the need for this cadre of workers are: Contractual arrangement is not encouraged due to financial implications of regularizing ASHAs in future; and the other reason is that general public are sufficiently aware of the health needs and come to health facility on their own

ii. State has 44% ASHAs in position against the target of 6850 under NRHM. There is a huge gap of 56% in rural areas and selection of ASHAs under NUHM Iis not yet initiated in the state.

iii. 23% of dropout seen and selection under this dropout is in process

iv. 1953 ASHA trained till round 4 of module 6 & 7. Training is in slow pace in Namakkal district. Few newly selected ASHAs have not received any induction training, but they have fair knowledge of activities from their field experiences.

v. In the Kuruvikulam block (Thirunelveli distt) visited, interaction with ASHA highlighted that on an average, an ASHA is earning Rs.1500 per month

vi. ASHA was well aware of all National Health Programmes and related activities and incentives.

vii. Majority of ASHAs interacted are intermediate and few are pursuing graduation. Some ASHAs are interested in joining VHN course after completing their five years of services.

viii. ASHAs have been provided with ID cards and uniforms. Supplies and availability of drugs and equipment is not uniform across the state.

ix. Grievance redressal committees are yet to be formed at district level.

x. 100% VHSNCs are functional in state, but state yet to initiate their reconstitution as per the new guidelines. Meetings of PWS (Patient Welfare Society) and VHSNCs are not being held regularly, and fund utilization is also not as per the guidelines.

15. Tripura

i. Overall state has 99% ASHA selection, and all of them have been trained in Module 6 & 7 upto Round 4.

ii. PHC monthly meeting are being regularly used as a platform for capacity building by accredited ASHA trainers, which is being supervised by state trainers periodically.

iii. ASHAs are mainly involved as DOTS providers, making slides/RDK testing for malaria (though lack of clarity on how to use RDK kits), spacing advise, home-based distribution of contraceptives, HBNC and menstrual hygiene scheme. High-risk baby format is not being filled.

iv. All ASHAs had drug kits and HBNC kits. The drug kits are replenished at the monthly meetings. However, a shortage was found in Sulema PHC.

v. In Dhalai, 85% of new born received HBNC visits, and only 50 % of them were weighed.

vi. The average monthly earnings (inclusive of the 33% add-on) showed an increasing trend (data across different PHCs in Dhalai)- Rs 1,600 in 2013-14; Rs 1,970 in 2014-15; Rs 2,585 in 2015-16, Rs 3,200 in 2016-17.

vii. State has activity-linked incentives for ASHAs, on which the state government gives an additional 33%. Payments are done through NEFT. Some of the newly selected ASHAs do not have bank accounts.

viii. In Dhalai district, there was a backlog of more than a year in payments.

ix. Each SDH/CHC/PHC has a designated ASHA Nodal Officer, usually an AYUSH Doctor who provides supportive supervision, with ASHA Resource Centres available at Sub-Division, District and State Level. However, the meetings of district and state level AMG/CHA groups were not regular (not even once a year).

x. ASHA Grievance redressal mechanism has been constituted but ASHAs are not aware about the process of registering a grievance.

xi. Performance monitoring measurement system is well implemented in the state. Low and poor performing ASHAs are identified and provided handholding support.

xii. ASHA rest room is available almost in every delivery points.

xiii. 10% seats for MPW (Females) have been reserved for ASHAs having at least 5 years of service and with necessary educational and other requirements.

xiv. VHSNCs are constituted at Gram Panchayat level; and ANMs and Pradhan are the joint signatories. The role of the ASHA is limited towards attending the meeting.

xv. CAH has been initiated in Gomati District as Pilot District, the committees have been set up at state and district level, and the state level orientation has been taken place.

xvi. 75.5% of MAS have been formed against the target of 106 and 80.4% of members are trained in two-day induction training.

16. Uttar Pradesh

i. Shortfall of ASHAs was noted in the state, as only 85% in rural and 72% in urban have been selected against the targets.

ii. State needs a systematic process of mapping all villages/areas where ASHAs are yet to be selected. Many ASHAs reported of covering over 2000 of population.

iii. Most ASHAs met during field visit reported covering over 2000 population. The districts have not yet done any systematic process for identification of areas uncovered by any ASHA. The average gap from the time of drop-out of ASHAs to the new selection was more than one year in Firozabad.

iv. State has made substantial progress in ASHA trainings in last 2-3 years. Presently, it has completed training of 65.3%, 64.8% and 0.9% ASHAs in Round 1,2 and 3 respectively. However, delay was noted in starting induction training after selection of new ASHAs.

v. HBNC kit was available with ASHAs but thermometers were not functional.

vi. ASHA payment systems have been linked with PFMS. In district Firozabad, on the initiative of District Magistrate, an innovative system of Drop-box has been introduced and ASHAs can deposit their payment vouchers in this drop-box anytime and the payment was done on a weekly basis.

vii. The state has a robust support structure presently. Support and review meetings are held and capacity building workshops are planned for ASHA support cadre at every level

viii. State has started the process of segregating the role of ASHA and ASHA facilitator since March 2016. Majority of ASHA facilitators have opted to continue working as ASHA facilitator's role, leading to a dropout of ASHAs

ix. Grievance Redressal Systemis in place at all levels with regular monthly meetings. However, in Firozabad, there was no documentation observed.

x. State has provided mobile phones to all ASHAs in FY 2015-16, and funds have been approved this year for giving bi-cycle to ASHA sanginis

xi. Mobile kunji and Mobile Academy applications have been implemented in the state, however it could not be observed in the field as the call could not be connected with "Dr. Anita".

xii. AAA is seen providing an effective platform for convergence mechanism.

xiii. The state has introduced an insurance scheme which provides an accidental cover to ASHAs and ASHA sanginis, with a financial assistance of Rs. 2 lakh in case of accidental death and permanent disability.

xiv. Reconstitution of VHSNCs as per the guidelines and formation of MAS is yet to be done in the state.


PHC - NDM
PMC - NDM

TOR 7 | INFORMATION and Knowledge

OBJECTIVES

- To review the use of various Public Health Information Systems and any duplication among them, use of Information generated from such sources for programme planning and monitoring, and status of addition of urban and private facilities into HMIS and MCTS web portal and its updation.
- To oversee availability of IT infrastructure alternative mechanisms for data uploading, availability of RCH registers and use of MCTS/RCH portal for generation of ANM work plans.
- To review the implementation of telemedicine and of m-health solutions if any, use of data from civil registration system, progress of health call centers, if any.

National Overview

Health Management Information System (HMIS) portal was launched in 2008 under National Rural Health Mission (now National Health Mission). The facility-wise data entry started in 2010 and currently about 94% of health facilities are reporting data on HMIS portal. The details of the reporting status of 16 CRM States/UTs are detailed in Table 1. Most of the CRM States/UTs are reporting above 90 % except for Arunachal Pradesh (68 %), Delhi (85 %) and Gujarat (82%).

Mother & Child Tracking System (MCTS) was launched in 2010. The main function of MCTS is to track pregnant women and children. It assures service delivery by generating work plans and due list for ANMs. It also supports referral for complications and high risk cases. In 2015, there were 2, 06,815 facilities registered in MCTS and out of this around 94% of facilities regularly report data into MCTS. It has now been replaced by RCH portal.

There are many health related software working in States in silos with limited capacity of sharing data with each other. MoHFW has recently established a set of standards for EHR systems. However, to further nurture and streamline growth of health informatics and to ensure participation of various information systems in information sharing MoHFW will be releasing semantic standards for interoperability and integration. Most of the States have started mapping Urban health facilities on HMIS portal.

Key Findings

In every State/UT, HMIS is operational and contributing in varying degrees to strengthen the health systems. The common constraints in optimal utilization of HMIS/MCTS/RCH portals were in the domain of a) data entry, b) completeness and timeliness of data being collected and uploaded, c) lack of standardized registers, d) need for training and imparting of enhanced skillsets for handling the technology, e) poor internet connectivity and f) inconsistent power supply. Many States/UTs are using HMIS data in preparing PIPs. Some of the States/UTs have utilized HMIS/RCH data for different developmental activities at different levels. Some key observations emerging out of 10th CRM are as follows:

1. HMIS & MCTS

i. Facility - wise data entry across all States has firmed up. All the 16 States/UTs of 10th CRM have reported HMIS data being uploaded from the public facilities and from (some) accredited private

Table 1: State wise data reporting status of facilities during 2015-16

States/UTs	Total Facilities						% Facilities Reporting during 2015-16					
	SC	PHC	CHC	SDH	DH	Total	SC	PHC	CHC	SDH	DH	Total
India	163539	31623	11025	2700	1220	210107	95.9	89.3	76.8	84.9	87.4	93.8
Andhra Pradesh	7455	1409	189	62	22	9137	99.7	99.5	100	98.4	100	99.7
Arunachal Pradesh	508	138	67	0	19	732	62.6	80.4	82.1	-	78.9	68.2
Bihar	10422	2071	67	41	131	12732	96.2	91.0	86.6	68.3	86.3	95.1
Chandigarh	50	43	3	1	4	101	100.0	90.7	66.7	0.0	100.0	94.1
Delhi	462	664	257	40	71	1494	90.7	84.5	74.7	87.5	84.5	84.8
Gujarat	9264	1795	1537	304	49	12949	87.6	86.2	53.0	51.6	83.7	82.4
Himachalp Radesh	2158	540	79	76	15	2868	99.4	87.4	70.9	98.7	100	96.3
Jammu & Kashmir	2579	711	135	0	31	3456	90.5	94.8	89.6	-	96.8	91.4
Jharkhand	4147	412	332	13	24	4928	95.4	86.9	92.8	100	100	94.6
Kerala	5812	941	229	355	52	7389	99.5	97.1	96.9	98.3	88.5	99.0
Madhya Pradesh	9485	1320	391	77	52	11325	94.6	96.0	95.1	98.7	98.1	94.8
Maharashtra	10605	2635	510	157	141	14048	99.7	84.3	79.6	89.2	56.7	95.6
Nagaland	557	149	29	0	14	749	96.2	93.3	96.6	-	100	95.7
Tamilnadu	8715	1901	420	289	33	11358	99.9	92.5	99.3	97.6	93.9	98.6
Tripura	1044	108	21	11	10	1194	99.4	89.8	85.7	100	90.0	98.2
Uttar Pradesh	20957	3382	3581	10	173	28103	99.2	90.7	67.6	60	94.2	94.1

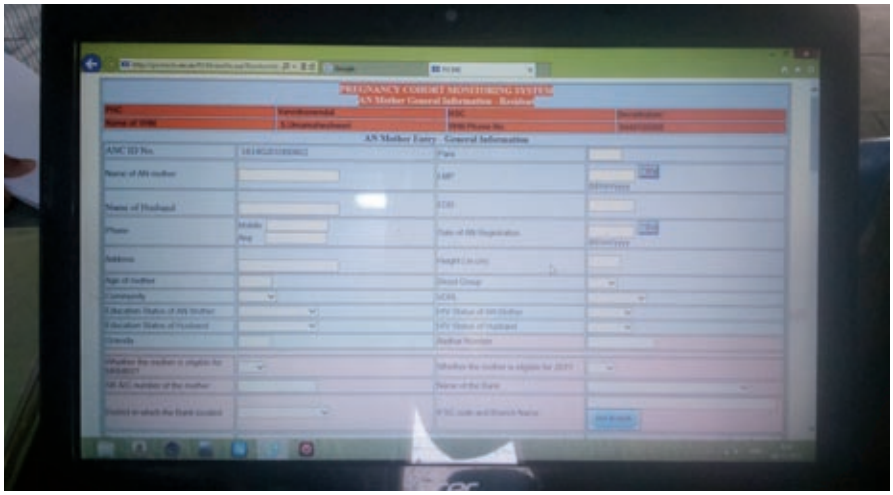
facilities. However, reporting from private facilities is still a a concern that needs to be addressed. Issues of data quality and completeness were observed in Delhi and Arunachal Pradesh due to non standardized registers.

ii. RCH portal has been reported to be fully operational in the States/UTs of Andhra Pradesh, Delhi, Himachal Pradesh, Madhya Pradesh, Maharashtra, Tripura and Uttar. Chandigarh is planning to roll out full implementation of RCH portal and integrated RCH registers in Dec 2016. However, the portal is not yet fully operational in Bihar, Arunachal Pradesh and Nagaland..

iii. Some technical glitches in RCH portal have been reported such as issues with synchronization of data from ANMOL tablet and RCH Portal in Andhra Pradesh, difficulty in entering account number & slow speed of the portal in Himachal Pradesh etc.

iv. RCH registers are available in most of the States (except in Delhi and Jammu and Kashmir), but it is not utilized optimally due to factors like incompleteness of data recorded in the registers and lack of training of the ANMs. In Jammu and Kashmir, RCH registers were available only in a few facilities. Poor quality and discrepancies in the data uploaded on HMIS/ MCTS/RCH portal and in the recording registers is an issue in Arunachal Pradesh, Delhi, Madhya Pradesh, Maharashtra, Nagaland, Tripura and Uttar Pradesh. Overall, there is lack of training of ANMs on RCH registers.

v. In context of capacity building in HMIS/MCTS/RCH, Andhra Pradesh, Himachal Pradesh, Tamil Nadu have reported



conducting regular trainings and Jharkhand, Kerala, Madhya Pradesh have reported sporadic trainings. Trainings related to the RCH portal has not been imparted at sub-district level in most of the States/UTs. Bihar, Chandigarh, Maharashtra, Tripura and Uttar Pradesh did not report of any training being conducted to build competencies in managing HMIS/MCTS/RCH portal. Arunachal Pradesh too reported lack of training in handling RCH registers, while in Nagaland, only an integrated training in RCH was conducted whereas, training for HMIS was not conducted. Monthly review meetings are reported from Chandigarh, Himachal Pradesh and Tamil Nadu only.

vi. Evidence based planning by using HMIS/RCH data for situation analysis, preparing PIPs, planning, monitoring, decision making and review of various activities on a regular basis has been reported by all the 10th CRM States/UTs except by Jammu and Kashmir and Nagaland. In Maharashtra HMIS data is used for planning at facility level and but not at district level. Though work plan is generated using RCH portal in Tripura, the HMIS data is not used extensively for planning and monitoring purposes.

2. IT Infrastructure for Health

i. Availability of good IT infrastructure in place has been reported by Andhra Pradesh, Bihar, Chandigarh, Delhi, Himachal Pradesh, Gujarat, Jammu and Kashmir (block level), Madhya Pradesh, Maharashtra and Tripura (PHC level) However, poor internet connectivity and power cuts are reported from Arunachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Nagaland and Tripura.

Table 2: Status of Urban Health Facilities Mapping as per HMIS

Sl. No.	State	Total Facilities mapped in HMIS(Urban)	% Reporting
1	Andhra Pradesh	416	86%
2	Arunachal Pradesh	7	71%
3	Bihar	1254	94%
4	Chandigarh	52	94%
5	Delhi	1140	87%
6	Gujarat	1233	73%
7	Himachal Pradesh	21	90%
8	Jammu & Kashmir	134	99%
9	Jharkhand	64	81%
10	Kerala	522	99%
11	Madhya Pradesh	553	93%
12	Maharashtra	769	83%
13	Nagaland	37	95%
14	Tamil Nadu	693	94%
15	Tripura	48	100%
16	Uttar Pradesh	651	85%

ii. There is a need to develop integrated e-health architecture with health information exchanges to integrate available information systems at the States. The States of Delhi (MIS), Himachal Pradesh (Hospital Information System) and Tamil Nadu (PICME) have reported their own HMIS, but most of these systems are operating in silos and there are issues when data is exchanged with these systems.

iii. Several Innovative IT based tools/applications addressing different local health issues have been reported by Andhra Pradesh (ANMOL, website on essential drugs & vaccines: www.core.ap.gov.in), Arunachal Pradesh (SNCU online), Bihar (DHIS-2, HRIS, Sanjvani, etc.), Chandigarh (zoning of health facilities), Delhi (Computerized Accidents & Trauma Services, Hospital Management Information System etc.), Himachal Pradesh (telemedicine & telestroke), Jammu and Kashmir (e-Aushadhi), Kerala (Ecman), Madhya Pradesh (Chetna, e-Aushadhi, EVIN etc.), Maharashtra (Matritva & EpiMetrics), Tamil Nadu (PICME, National Oral Health Mobile app, Dengue Fever Tamil app, Online Works Monitoring System, etc.) and Uttar Pradesh (Mobile kunji flip).

iv. In field of telemedicine and m-health, Himachal Pradesh has reported availability of telemedicine and Tele stroke services in remote areas. The availability of telemedicine services is also reported in Madhya Pradesh and Maharashtra.

v. Geo-coordination of public health facilities in HMIS and National Health Portal has picked up. While Chandigarh, Tamil Nadu and Gujarat have reported mapping of all, Himachal Pradesh too has reported 96% of its health facilities to be mapped.

vi. As per HMIS data, most of the urban health facilities in CRM States/UTs are mapped and are reporting on HMIS portal. Reporting by urban health facilities of most of the CRM States/UTs on HMIS was over 90 % except by Andhra Pradesh, Arunachal Pradesh, Delhi, Gujarat, Jharkhand, Maharashtra and Uttar Pradesh.

vii. On average, 87 % of the mapped facilities of the CRM States/UTs are reporting on HMIS portal. Details are given below in Table 2:

States needs to establish institutional mechanism to for collecting data from urban local body (ULB), which is required to understand the urban health scenario holistically. Further, there is also a need to capture more data related to urban indicators in the HMIS.

Recommendations

1. HMIS & MCTS

- Data entry points:
  - For PHCs having adequate infrastructure and manpower, HMIS/MCTS/RCH entry should be done at PHC level.
  - Institutional mechanisms for Cross validation, verification, authentication of data must

be strengthened before it being uploaded to the portal in States.

- Efforts should be made to ensure Private sector reporting under HMIS.
- States/UTs need to ensure 100% reporting of the data in HMIS/MCTS/RCH portal.

Capacity building: Integrated training program and training calendar needs to be developed for various levels of users to promote data utilization. These can include trainings on SDG indicators, NUHM and NCD information needs.

- Promote optimal utilization of HMIS:
  - HMIS/MCTS/RCH data must be utilized for planning and monitoring and generating evidence for corrective action.
  - Integration of different data from different sources (MCTS/RCH and IDSP call centres) should be explored on some set standard compliant norms as per GoI notifications. Moreover, States/UTs should be encouraged to use HMIS/MCTS/RCH data to triangulate with demographic and other survey data to get an overall health profile of the district for prioritizing blocks or geographic pockets for action.
- Feedback&GrievanceRedressal System: Feedback from the end users of the HMIS/RCH and other ICT related tools to be used for gap filling and further improvement.
- Dissemination of data: Better sharing of data and program outcomes may be facilitated with use of technology and portals among various departments. This will help in better convergence of other departments like sanitation, water supply etc. for State/UT and district level planning of service delivery.

2. IT Infrastructure for Health

- Infrastructure:
  - Alternative methods like VSAT, data cards, etc. for providing reliable internet connectivity and generators/solar power/inverters etc. for power supply in hilly areas should be strengthened.
  - Capacity building and other HR requirements should be addressed on a priority basis.
- Digitalization of health management inventory:
  - Payment transfer under PFMS to JSY and JSSK beneficiaries should have MCTS/RCH IDs for future tracking.
  - Explore the implementation of eRakt Kosh for managing operations of blood banks in phased manners for citizens and service providers.
  - Mobile based monitoring mechanism (like WhatsApp group for RBSK, ANMs, M&E etc.) across facilities may be explored.
- Telemedicine:
  - Promote implementation of telemedicine, especially in areas with difficult terrain and limited resources.
- New Technologies:
  - States/UTs should be encouraged to adopt programme/product innovations that were selected for presentations in the Innovation Summit.
  - Implementation of ANMOL, Kilkari and mobile academy at the earliest to improve data entry on RCH portal and health awareness among beneficiaries.
- Mapping:
  - Data capturing for all Municipal corporations & urban needs to be ensured.
  - All the UPHCs should be mapped on to HMIS and MCTS immediately.

State Findings

1. Andhra Pradesh

HMIS & MCTS

- Health Management Information System (HMIS)

data is well maintained and uploaded regularly at all levels of the facilities. HMIS data reporting matches with recording registers.

- All the District Hospitals have been mapped under HMIS.
- State level Training programmes and review Meeting for Data Entry Operators are conducted periodically.
- RCH portal (MCTS) has been launched in the state and beneficiaries are provided with RCH Id number. RCH registers maintain all the information related to beneficiary.

IT Infrastructure for Health

- Internet connections and IT facilities are available at DH, CHCs, and PHCs.
- ANM Online (ANMOL) has been operational in the state and 11,697 Tab PCs have been issued with Internet facilities to the ANMs to upload the data related to Immunization, Family Planning and Mother and Child.
- State and District level data related to essential drugs and vaccines are available and are also being uploaded on the state website www.core.ap.gov.in.

2. Arunachal Pradesh

HMIS & MCTS

- HMIS data is being used for situation analysis, preparing PIPs and for the review and monitoring of programmes.
- HMIS data uploaded and data recorded in registers matched.
- There are no standardized registers and hence some data elements are missing in the registers.
- RCH registers are available at all level but underutilized due to lack of training.
- State level training has been conducted for District Data Managers but not below it.
- There is a need of training for MO's BMO's and ANMs.
- RCH portal has been implemented in the state but Entry from SC, PHC, and CHC in new RCH portal has not been started.

IT Infrastructure for Health

- The facilities have adequate IT systems across districts but internet connectivity was poor and hence district data manager has to prepare the monthly report on hard copy.
- SNCU online software is being used for monitoring and tracking of SNCU admission.

3. Bihar

HMIS & MCTS

- Data is being uploaded timely in the form of monthly HMIS report on HMIS portal by all health facilities/institutions.
- 99% of the facilities reported on status of annual health infrastructure on HMIS portal.
- HMIS data is used for reviewing healthcare service delivery.
- HMIS reported data is analyzed regularly and a feedback mechanism is found to be in place.
- RCH portal has been launched in the state but it has not been fully operational.
- RCH registers are available in most of the facilities.
- The registers are not filled properly and there is huge backlog of data entry on RCH portal.

IT Infrastructure for Health

- Below listed web based IT Applications are being used by the state:
  - DHIS2 (District Health Information System)
  - HRIS (Human Resource Information System)
  - Sanjivani
  - RBSK Web Portal
  - Supportive Supervision Web Portal
  - Dashboard

- Health Grievance Redressal & Medical Advise System
- PFMS (Public Financial Management System)

4. Chandigarh

HMIS & MCTS

- All the facilities are reporting on the HMIS portal.
- HMIS data is being used for planning, monitoring, decision making and review of various activities on a monthly basis.
- NHM Chandigarh is planning to roll out full implementation of RCH portal and Integrated RCH register in Dec 2016.
- Monthly Review meeting is conducted to monitor the quality of data for uploading on HMIS portal.
- All the Health facilities have been mapped and national identification number has been generated for all the facilities in HMIS and MCTS.
- All facilities are linked with Geo-coordinated in HMIS and National Health Portal.

IT Infrastructure for Health

- All the facilities have been provided with Computers and Internet connectivity.
- Zoning of Health Facilities has been adopted under M&E/ HMIS for timely reporting of data and monitoring the health care delivery services.
- 32 facilities are mapped as Urban Health facilities

5. Delhi

HMIS & MCTS

- 85% of the facilities are uploading on the HMIS portal.
- Data quality is an issue there because of non- standard registers especially at secondary and tertiary care institutions.
- Due to lack of coordination between agencies like Delhi Government, MCD, CGHS, Central Govt. Hospital, ESI, Railway and Army Hospitals, there is incomplete data on HMIS portal.
- HMIS and MCTS data is being used for making decision, plans and strategies at state and district levels.
- Most of the facilities are not maintaining signed hard copy of the monthly HMIS formats.
- Most of the facilities lack new RCH registers.
- RCH portal has been updated and online work plan for ANM is done in the state.

IT Infrastructure for Health

- Most of the facilities have been equipped with computer, printer and internet facilities.
- Delhi has developed a state owned MIS for catering to the needs of the state and monitoring the performance.
  - Computerized Accidents & Trauma Services (CATS)
  - Hospital Management Information System
  - Civil Registration System – all the major Government/ Private hospital have been provided the facility of online reporting of births/deaths.

6. Gujarat

HMIS & MCTS

- 82% of facilities are reporting on portal and HMIS data is being used for planning at state and district levels.
- Mapping of all facilities in the urban and rural areas has been done.
- RCH registers are being maintained at PHC and Sub Centre level but not at SDH and above.
- Work plans are generated on every Tuesday and shared regularly with the facilities that go for immunization and Ante natal Checkup.

IT Infrastructure for Health

- All the facilities in the visited districts have been provided with adequate infrastructure, power supply

with power back and internet connectivity.

7. Himachal Pradesh

HMIS & MCTS

- 96% of the facilities in the state are reporting data on HMIS portal.
- Geo-mapping of around 96% of the facilities is done in the state.
- HMIS data are verified and signed by concerned official before uploading on HMIS portal.
- Training of HMIS persons are not conducted regularly.
- Periodic meetings are conducted at district and block level
- RCH portal has been implemented in the state and the training of DEOs has been completed in all the districts.
- RCH registers are available in all the visited facilities.

Health ICT Infrastructure

- Most of the block level facilities have been provided with computer with internet connectivity.
- State has implemented Hospital Information System across 20 Hospitals and 2 PHCs (12 DHs and rest 100 bedded Hospitals).
- Telemedicine and Tele stroke services have been introduced in the state to deliver services in the remote areas.

8. Jammu & Kashmir

HMIS & MCTS

- 91% of the facilities reporting on portal and monthly facility wise performance data are available in the facilities.
- Correct data entry is observed in the visited facilities.
- Validation of data at supervisory level is very limited.
- ANMs find it difficult to fill the registers due to their limited training.
- HMIS data is not used in planning and monitoring of the deliverables of the programmes in the state.
- MCTS data is used for tracking mother and child.
- RCH registers are available only with few facilities.
- Training programmes for new DEOs and block level M&E officers is not conducted.
- Training in HMIS was given during 2012-13 but since then, there has not been any refresher training.

IT Infrastructure for Health

- Internet and computer systems are available at block level for uploading data on HMIS and MCTS.
- *E-Aushadhi* application has been adopted by the state recently for implementation of Free Drug Services.

9. Jharkhand

HMIS & MCTS

- Implementation of MCTS in terms of registration and timely service updating needs significant improvement.
- MCTS data show poor service delivery for pregnant women for ANC check-ups and children for immunization. In 2016 (till the time of 10th CRM visit), only 36 % pregnant women and 32 % children were registered on the system.
- Capacity building exercise in the form of HMIS Training are held with the latest being on 22/06/2016.

IT Infrastructure for Health

- Most of the facilities below district level have the common issue related to poor internet connectivity.
- Values reported on HMIS matched primary registers in most of the places.

10. Kerala

HMIS & MCTS

- Data from HMIS and MCTS are periodically reviewed and used for planning at the state and district level. However, these data are not used for planning below district level.

- Data from all the private accredited facilities are captured in HMIS and MCTS.
- Service data registers are available and well maintained. No variation was found in HMIS/MCTS data and primary registers.
- Regular HMIS training of new recruits is an issue. The last such training was conducted in 2012-13. Medical officer is not aware of grading/rating of CHCs.

IT Infrastructure for Health

- Problems of Internet connectivity, electricity and power back up exist at some facilities.
- "*Ecman*"- an online reporting system capturing activities of ASHAs and linked to the honorarium payments is operational.

11. Madhya Pradesh

HMIS & MCTS

- Though HMIS data is used to monitor service delivery at state level and reviewed regularly at district and block levels, use of HMIS data for monitoring various districts and various programme varies.
- Training in HMIS was needed and lack of it has resulted in either discrepancies in HMIS data and service registers in some places for some indicators, lack of quality of data or non-utilization of HMIS/RCH utilities.
- MCTS data is used for micro planning.
- Training in RCH portal has been imparted up to the block level. Only 15 % of ASHAs have successfully completed Mobile Academy course. IT Infrastructure for Health
- IT infrastructure is available at all levels (PHC, CCHC, SDH and DH), but internet connectivity is poor. Data entry is not done in some places even though infrastructure is available due to connectivity issues.
- There are 3 call centres in state headquarter (MCTS, JSSK and IDSP). The MCTS call centre was being used to review service delivery to beneficiaries and logistics delivery to ANMs on VHNDs (Tuesday and Thursday). But data of these call centres are not integrated in a single dashboard resulting in its sub-optimal use.
- A telemedicine centre has been provided at State HQ where specialists deputed by State HQ will attend to the patients at 5 pilot nodes.
- IT tools like CRS software of RGI, *Chetna*- mobile application, application for CDR, *e-Aushadhi*, EVIN, PFMS etc. are being used in the state.

12. Maharashtra

HMIS & MCTS

- HMIS is working well and most of the data of HMIS and registers matched.
- At SC level, health worker has to maintain 39 registers exerting excessive load on health worker.
- At facility level, HMIS data is used for planning services (Immunization, ANC activities, deliveries, outreach activities, etc.) but at district level, HMIS data is not used for planning and there is lack of data analysis to ensure better services.
- At secondary and tertiary level, facility-in-charge is not getting involved in HMIS data analysis and usage resulting in poor data quality of HMIS report from corporation.
- RCH portal is now operational for individual line listing.

IT Infrastructure for Health

- ASHA software is used for monitoring ASHA performance and disbursing incentives.
- Telemedicine facility is utilized well with doctors seeking offline and online consultations from experts in medical colleges and corporate hospitals.
- Two IT based applications has been initiated- *Matritva* (application to detect high risk pregnancies) and *EpiMetrics* (application to prevent health disasters).

13. Nagaland

HMIS & MCTS

- HMIS data was not put into use for planning activities, performance monitoring, service delivery, supportive supervision etc.
- MCTS has been replaced by integrated RCH portal but RCH IDs along with other vital data (hemoglobin, urine albumin and sugar, birth weight, no. of IFA tablets given, other parameters of high risk pregnancy) were missing.
- Death reporting is poor at all levels.
- Integrated RCH portal training (1st phase) up to block level programme managers has been completed, but HMIS training was not conducted.
- No work plan based on RCH registers has ever been generated in the state.
- Multiple reporting (information is captured separately through HMIS and Statistical Department of Government of Nagaland) and multiple formats caused duplication of data, delays, confusions and errors in collection of data.
- Tracking of beneficiaries by ANM is poor.

IT Infrastructure for Health

- No telemedicine or m-Health initiatives have been rolled out in the state.
- Available IT infrastructure is not used owing to difficult terrain, lack of physical connectivity and poor network of phone and internet.
- Inventory management is not computerized.

14. Tamil Nadu

HMIS & MCTS

- Tamil Nadu has a very robust information and management system. HSC wise data is collected by VHN which is verified by Sector Health Nurse and then by block DEO. Additional Director (SBHI) validates the information uploaded to NRHM HMIS.
- HMIS data received is used effectively for formulation of State/District Health Action Plans, review and monitoring. Timely and corrective feedback is provided at all levels.
- All public health facilities have been mapped and incorporated in HMIS, including all urban public health care facilities. Private health facilities have not been mapped.
- *Standard format/register* for record keeping for labour room, immunization, family planning activities were lacking.
- Trainings on HMIS/PICME/MCTS are held periodically. 7 state level workshops were held last year (2015).

IT Infrastructure for Health

- Since 2008, PICME (Pregnant and Infant Cohort Monitoring and Evaluation) - State owned software is operational capturing maternal and child details at the level of HSC. Relevant data are moved automatically from PICME to MCTS but there are discrepancies in data because of different technicalities.
- Work plans for VHNs are being generated through PICME.
- Several IT initiatives are operational which include- *National Oral Health Mobile app*, *Dengue Fever Tamil app*, *Online Works Monitoring System* etc.
- There are 473 active urban PHCs and there was a gradual increase in reporting, from 450 in April, 2016 to 461 in September, 2016.

15. Tripura

HMIS & MCTS

- Facility-wise data is fed to HMIS regularly and registers containing service data is available at all levels.
- The RCH registers and work plan are sent to the data entry points for RCH portal by ANMs on regular basis.
- Work plan generation at RCH portal is very slow (only 5-6 IDs generated per day) due to problems in internet connectivity and power cuts.

- HMIS data is not used extensively for planning and monitoring purposes.
- Some discrepancies between the recording register and reporting on HMIS portal was observed. Similarly, some of the services provided at facilities were not reflected in the HMIS record (e.g. Insertion and removal of IUCDs).

IT Infrastructure for Health

- Infrastructure facilities are available at PHC level but are inadequate along with internet connectivity issues.
- There is shortage of trained manpower.

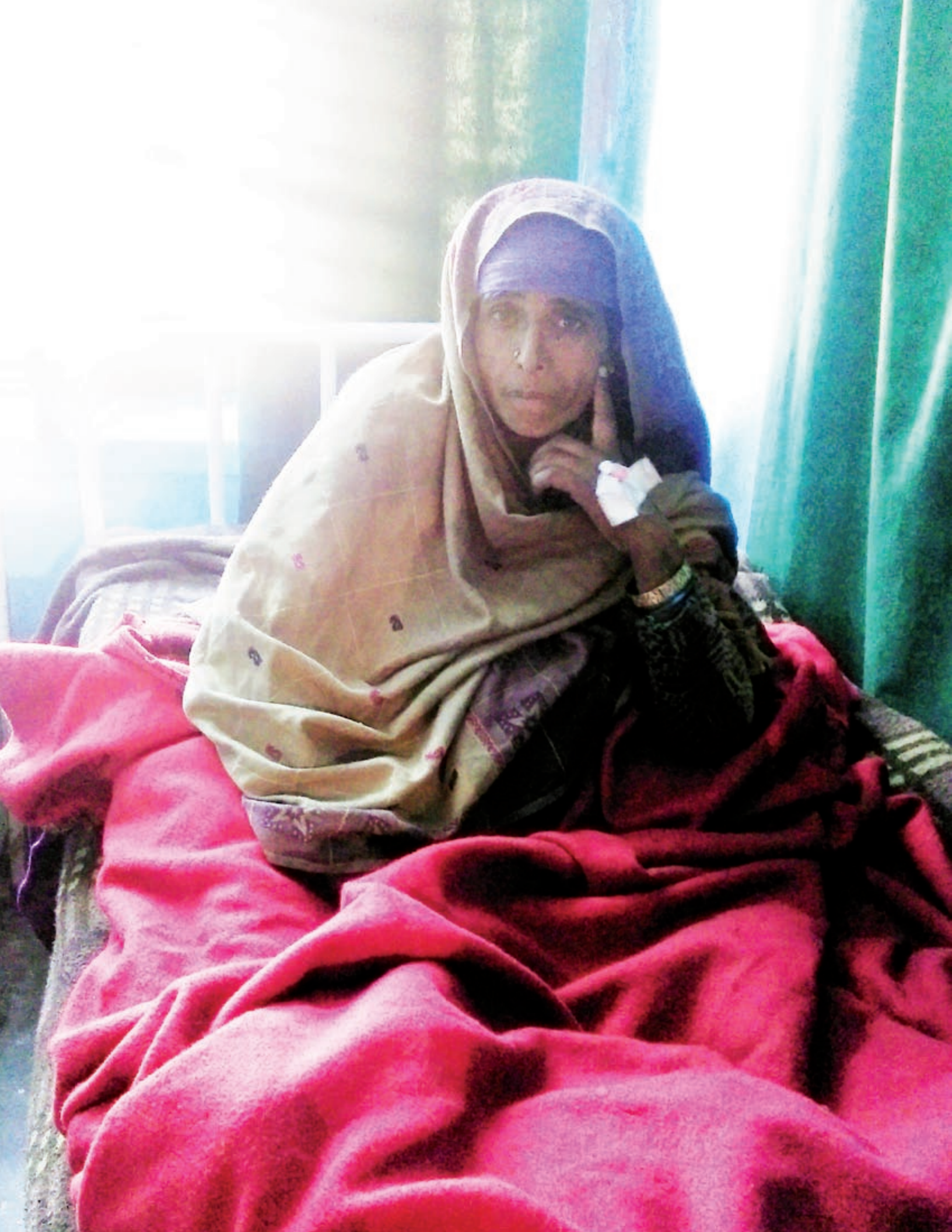
16. Uttar Pradesh

HMIS & MCTS

- Facility level data is reported to HMIS portal on regular basis.
- MCTS is functional in all districts and data is entered by MCTS operator at CHC/BPHC and above level from registers of ANMs.
- RCH register is available at all rural facilities and work plans are generated on regular basis with the help of MCTS portal.
- ANMs are aware about HMIS formats at SC level but awareness about new RCH register is low.
- Record keeping at facility level needs to be streamlined with the standard HMIS format.
- Data in HMIS portal and recording registers do not match.

IT Infrastructure for Health

Mobile kunji flip cards are found with all the ASHAs.



TOR 8 | HEALTHCARE Financing

OBJECTIVES

- To review the status of fund release and utilization against the approved activities and financial allocation to High Priority Districts (HPDs).
- To oversee fund flow mechanisms and implementation of Public Financial Management System.
- To review adequacy and effectiveness of finance management, utilization of untied funds and adoption of differential financing.
- To examine compliance of statutory matters.
- To document measures taken by the Public facilities to reduce the Out of Pocket expenditure (OOPE).

National Overview

From its inception in 2005- 06 to March 2016 about Rs.1.33[1] Lakh Crore has been released under National Health Mission by the Union Ministry of Health. Sound financial management is a critical input for decision making and programme success. Accurate and timely financial information provides a basis for informed decisions about the programme, fund release and assists in reducing delays for smooth programme implementation. States have been encouraged to build effective financial management capabilities which is critical for ensuring that programme implementation does not suffer. To provide additional flexibility to the RKS to prioritise need based expenditure and to obviate the cumbersome process of transfer and accounting of three separate small amounts of untied funds, the untied grants provided to facilities as Untied Grant, RKS corpus Grant and Annual Maintenance Grant were pooled into a single untied grant to the facility. Provision was also made for differential financing to allow for responsive allocation to facilities based on caseloads, fund utilization, and range of services. To address high OOPE, NHM has been supporting many interventions including provision of free essential drugs and diagnostics, free ambulance services and JSSK entitlements which include free blood services besides free diet, drugs, transportation and blood services.

1 National Health Mission, State wise progress as on 31.03.2016, Ministry of Health and Family Welfare, Government of India

Key Findings

Key findings emerging out of various CRM States reports are as follows:

1. So far as utilisation of funds are concerned, across the States that have been visited, reports indicate improvement in utilization of funds in almost all the States. States have also improved their capacity in financial management. The issue of vacancies in State finance HR that were repeatedly flagged in CRM reports of earlier years seems to have been largely overcome in most of the states visited barring a few such as Tripura and MP.

2. Most of the CRM States have put in place systems

for transfer of funds through electronic transfers barring States in the North East like Nagaland and Arunachal Pradesh. However, delay in transfer of funds from State treasury to State Health Societies (SHS) continues to be a major problem with most states with delays ranging from 30-45 days in Gujarat, 40-42 days in Tamil Nadu, 88 days in Kerala to 75-90 in Delhi.

3. Barring Tamil Nadu none of the States were found to have allocated additional funds (at least 30% per capita) for HPDs. Allocation of funds have been found to be made based on utilisation of previous years. In most States, district RoPs have been disseminated barring Nagaland.

4. Fund utilization is particularly low under NUHM and NCD programs. Bihar has reported the lowest utilization of funds amongst CRM States under NCD programs.

5. As regards implementation of PFMS is concerned, while all States barring Nagaland has implemented PFMS, the progress of implementation shows it is at varied stages of implementation. HP and Tamil Nadu are states with 100% agency registration followed by Gujarat with 97%, MP with 95%, UP with 84%. Overall implementation of PFMS in Tripura is reported to be unsatisfactory throughout all the facilities as only 67% agencies have been registered under the PFMS portal with pendency at District and below level. As far as transfer of fund through PFMS portal, in Tamil Nadu, all the funds are being transferred from the State to the Districts and District to Sub District Level through PFMS. In UP, all the financial transactions including JSY beneficiary/ ASHA/Contractual staff/ Family Planning Schemes up to the CHC/PHC level are being done through the PFMS portal. In MP, payments towards ASHA incentive and JSY beneficiary are being paid through DBT using PFMS. However, reportedly, in Chandigarh has not only implemented online financial management through PFMS but also FMR generation through PFMS.

6. As regards untied grants, despite issue of guidelines for differential allocation of untied grants, none of the CRM states have reported adoption of differential financing of untied grants. Poor utilisation of untied grants is still an area of concern. In UP and Chandigarh, there were sub centres with nil utilisation of untied grants. Kerala had not distributed the untied grants approved in 2015-16 to facilities while in J&K, fund disbursement to VHNCs has not been made from last 3-4 years. In HP, RKS funds were being utilised for programme expenses despite the programs having sufficient funds.

7. The all India performance audit for the period 2011-12 to 2015-16 by CAG completed in all States. The statutory Audit for 2015-16 was completed but final report awaited in most CRM States while it was under process in some states. Across States compliance of concurrent audit was found to be poor. It is observed that the auditors were not visiting the Block level facilities and were verifying the records at district HQ itself defeating the purpose of conducting the same. The Concurrent auditor for the F.Y. 2016-17 was not appointed in MP while compliance on the Statutory Audit and Concurrent Audit are not followed in J&K.

8. Amongst the 16 States/UTs visited during CRM, Andhra Pradesh, Arunachal Pradesh, Chandigarh, Bihar, Jharkhand, Uttar Pradesh and Maharashtra have not commented/ collected information on measures undertaken by the States to reduce OOPE. Similarly most States except Gujarat and Kerala did not report information on state health insurance programs. In Gujarat the awareness of RSBY program was found to be low and people were only aware about the state sponsored MA program.

9 Barring Tamil Nadu and Dehi, reports indicate some form

of out of pocket expenditure by patients even in States like MP, Gujarat, Kerala, HP mostly on blood services, transportation and drugs. The cost incurred towards blood services range from Rs 300 to Rs 1500. Kerala has reported discontinuation of reimbursement of expenses to patients towards transport and diet under JSSK due to non-receipt of funds from July 2016.

Recommendations

i. States need to ensure that the flexibility in diversion of funds between pools is used only when it is necessary and not make it a regular practice by ensuring better planning and use of resources.

ii. States should adhere to the banking guidelines prescribed by the MoHFW and implement it at the state and district level and not carry out transactions through a single account.

iii. States have to address the issue of bank integration and ensure synchronisation to avoid transaction delays.

iv. Settlement of long standing advances and unspent balances needs to be addressed by States to avoid differences between the balances shown in books of district and sub-district level accounts.

v. Per capita allocation of funds to High Priority Districts should be made as per norms.

vi. In order to address high OOPE, States should explore the reasons for high OOPE on drugs, diagnostics, transport, blood, etc, despite the programs such as free Drugs and Diagnostic Schemes and JSSK.

vii. JSSK funds should not be diverted for other activities and strict monitoring is required on the use of these funds.

viii. States should utilise untied funds to purchase essential drugs and maintenance of facilities when they are constrained with raising own resources through local self-governments and other means.

ix. States need to make arrangements for setting up computerised registry of stock of medicines to mitigate differences in the list of stock of medicines available in the stock register and the physical count of medicines at the facilities.

x. States need to appoint a NHA Nodal Officer and provide a budget for institutionalisation of State Health Accounts (SHA).

xi. Awareness about the RSBY insurance program needs to be improved and if possible integrated with other state insurance program.

Other recommendations including those that were made in the 8th and 9th CRM and have not been addressed by most States and require immediate attention are:

i. The recruitments of finance personnel and accountants positions need to be completed at the district level on a priority basis to ensure bookkeeping and better management of funds.

ii. Transfer of funds from State Treasury to the State Health Society should be released on time to effectively utilise the funds. States also need to examine regularly the areas and reasons for underutilisation of funds and provide supportive supervision for making corrective actions for better utilisation of funds.

iii. States need to address delays in transfer of funds under JSY, JSSK such that the benefits reach target groups on time and also make timely payments to staff and incentives for ASHAs.

iv. Capacity building on PFMS training is essential for accounts staff at the district and block levels for expenditure filing and MIS reporting through PFMS.

v. The Tally ERP software should be integrated with the PFMS

to avoid duplicity of work and all finance and accounts personnel need to be trained on using the software.

vi. Concurrent audits require physical assessment of facilities and reports should be based on thorough verification of all aspects that form the basis for audit. States need to take necessary steps to follow up on the actions that are proposed in the Concurrent Audit reports.

vii. States need to utilise the RKS funds for patient welfare or for any urgent medical needs at the facility level and not utilise the money under this fund for purchase of fixed assets.

State Findings

1 Andhra Pradesh

i. There are several vacant positions in the state and the district level for financial staff. Key Positions like Director Finance and State Finance Manager are vacant.

ii. The overall utilisation of fund under NHM for the F.Y from 2013-14 to 2015-16 was very low. The State and Districts have reported very less utilisation of funds under NUHM, NDCPs and NCD Programmes.

iii. No delay reported in transferring funds from State Health Society to District Health Society & from DHS to Block Level.

iv. Banking Guidelines prescribed by Ministry has not been followed at State and District level. All transactions for different programs of NHM are being carried out from one bank account though there are separate accounts opened for each program. So there was diversion of funds from one program to another program.

v. Separate RKS Audit has not been implemented at State and District level.

vi. The CAG performance audit for the period 2011-12 – 2015-16 has been completed.

vii. Separate ledger and cashbook were not maintained for each programme in the State and District level.

viii. At SHS and DHS level books of Accounts has been updated at regular basis but maintained manually.

ix. Tally ERP 9 Accounting software is not implemented for maintaining the books of accounts at the State and District level.

x. E-filing system has been implemented in the State.

xi. No procedure has been followed for knowing the current position of bank balances of each programme.

xii. There are no user charges collected at CHC & PHC level. The user charges collected at District Hospitals are being deposited in the (RKS) accounts and the same are being properly utilized.

2. Arunachal Pradesh

i. There is an overall under-utilization of RKS funds. Frequency of RKS meetings was found inadequate held only once in a year to grant approvals for the expenditure.

ii. District RoPs have not been disseminated. The dissemination process needs to be expedited.

iii. There is a backlog of incentives to be paid to the JSY beneficiaries in almost all the health facilities though they have sufficient funds with them under other heads.

iv. Incentive to ASHAs under JSY is paid at lower rates by General Hospital, Pasighat (Rs.580/- instead of Rs.600/-).

v. All the payments, DBT and Non-DBT, and expenditure filing should be through PFMS only. As per mandate of Ministry of Finance 100% PFMS compliance should be maintained in the current financial year itself.

vi. Concurrent Audit for the F.Y. 2016-17 has not been initiated although auditors

have been appointed. It was noted that ATR on previous year's Statutory Audit and Concurrent Audit is yet to be submitted.

vii. User-fees bank account is not opened in the name of facility concerned, but in employee's name.

viii. Huge OOPE incurred (both JSSK and Non JSSK) on diagnostics: In one CHC, one of the patients was paying Rs 3000 for drugs and 3200 Rs on Diagnostics. The other patient reported that he paid for Rs 300 for basic drugs and Rs 60 for diagnostics. In the labor ward, one of the patient's informed that she paid Rs 100 for Ultrasonography and Rs 40 was charged for Hb test.

3. Bihar

i. Key position of State Accounts Manager (SAM) is vacant. 4 out of 38 sanctioned District Accounts Managers and 90 out of 534 sanctioned Block Accountants are vacant.

ii. Delay in the crediting of the State share. This leads to non-fulfillment of DOE conditionality of state share contribution and thus funds are not released by the Centre.

iii. Delay in transfer of funds from State Treasury to SHS i.e. 60 -65 days against the prescribed maximum period of 15 days by GOI.

iv. Overall a very poor utilisation rate is observed with none of the pools having more than 20% utilisation by the end of 2nd quarter of 2016-17. Further expenditure as low as 1 % is NCD programmes like NPHCE, NTCP and NPCDCS.

v. Temporary diversion of funds between pools is done to meet expenditure under major pools of expenditure like RCH and MFP. However it has become a norm rather than the exception as suggested by GOI guidelines

vi. Funds are transferred from Treasury to SHS through Personal Ledger Account. The Facility of e-transfer is available up to PHC level only.

vii. User charges are being collected in both the districts of Siwan and west Champaran under RKS subject to certain exempted groups like pregnant mothers, senior citizens and accident cases.

viii. Poor financial management at the block levels in terms of ineffective book-keeping mainly due to lack of human resources causing unnecessary burden on District Accounts Manager.

ix. Lack of proper convergence of accounts at the State level due to absence of SAM and as a consequence there is delay in submission of information for preparation of Statutory Audit and Concurrent Audit Reports.

x. There is a major discrepancy to the tune of 98 crores as evidenced by the comparison between the total expenditure as reported under FMR for 2016-17 up to 30.09.2016 and expenditure data generated by PFMS up to 30.09.2016. It reflects payments being made via cheques which is in violation of the guidelines

xi. Incomplete registration of agencies under PFMS. 25% of agencies at the level of APHC, HSC and VHNSC are yet to be registered under PFMS.

xii. FMS-Bank integration issue as real time synchronisation is not happening in practice. This leads to unnecessary delay in processing the transactions at the bank after Print payment advice is generated through PFMS.

xiii. Most JSSK benefits are not being provided to mothers and they are incurring OOP.

4. Chandigarh

i. There is no systematic orientation/training provided to the finance and accounts staff at sub-district level; leading to inadequate understanding of financial guidelines and weaker financial management at the CHCs/PHCs and lower level.

ii. Online financial management and FMR are done through PFMS.

iii. There is timely release of funds for respective activities on RKS, VHSNC & untied grant.

iv. There are huge unspent balance under NUHM (Rs.467.42 lakhs), Immunization (Rs.40.43 lakhs), RNTCP (Rs. 101.50 lakhs) and NIDDCP (Rs.16.72 lakhs).

v. E-transfer has been implemented up to the block and below level.

vi. RKS Auditor appointment is pending for F.Y. 2016-17 in five Blocks.

vii. The supply of medicines is not as per requirement, a push factor has been found instead of indenting.

viii. UCs under certain schemes like under flexible pool for Non Communicable Diseases etc. are still pending for settlement.

5. Delhi

i. The human resource positions under Finance and Administration remain vacant at the facility level. The state needs to fill in the full time positions of Accountants, Accounts Assistants and Finance Consultants to enhance the quality of work.

ii. There is a delay of 75-90 days in receiving funds from the State Treasury to the State Health Society. Timely transfer of funds to State Health Society will enable the District Health Society to transfer funds to the concerned departments that have placed fund request and aid in better utilisation of funds.

iii. Low levels of utilisation of NUHM funds as only 20 per cent of funds have been utilised from the total allocation during the Financial Year 2015-16. Similarly, only 30 per cent of the approved budget have been utilised under NRHM flexi pool. Supportive supervision should be made on regular basis for improving fund utilization and timely reporting.

iv. Funds are released without considering the unspent balances. Strict follow-up measures are required for settlement of old advances.

v. Compliance to concurrent audit needs improvement as there has been no action taken on the Concurrent Audit report that was completed in November 2015.

vi. Expenditure filing on PFMS has not been initiatedand PFMS training is required for MIS reporting through PFMS. Accounting software (Tally) may be integrated with PFMS in order to avoid duplicity of work.

vii. No Out-of-Pocket expenditure was incurred by patients who visited public health facilities.

6. Gujarat

i. The expenditure reported in FMR from the State to GoI is not tallied with books of Accounts of the State Health Society. The state needs to book expenditures on a monthly basis for the District and other Reporting Units.

ii. Interest earned under NHM funds at District and sub-district level from different bank accounts are not considered, which amounts to around Rs.100 crores.

iii. Understating of unspent balance since inception of NHM was observed, as a result there is a difference between the balances shown in books of district and sub-district level accounts.

iv. The RKS funds were not being used for patient welfare and/or urgent needs at the facility level.

v. Taking refunds from lower facilities is not permitted as per the NHM guidelines. The unspent balance should to be left at the Health Facilities for on-going Activities.

vi. Fund was released to Taluka/CHC during FY 2016-17 without considering the unspent balances as on 31st March, 2016.

vii. No expenditure booked against the fund released during the FY 2016-17.

viii. Poor inventory management, resulting in regular stock outs, leading to purchase of medicines (otherwise available from GMSCL) at markets rates using JSSK funds (on urgent basis).

ix. The focus of the health insurance officials at state and district level seems to be more on MA/MA Vatsalya scheme and not on the RSBY scheme. It is indeed a missed opportunity, since a BPL family is entitled to both MA and RSBY schemes that are designed to provide complementary sets of healthcare services/ packages.

x. A low level of community awareness about RSBY was observed during patient interaction. Families registered under MA were not found to be registered under RSBY and also did not know about eligibility criteria and the benefits under the RSBY scheme.

xi. No or "Rs 0" Out of Pocket expenditure on drugs and diagnostics by patient in/ at any of the public facilities visited.

xii. Some of the BPL patients were observed to be spending (OOP) on transportation (Rs 500 –1000 one way) and blood (Rs 1000 – 1500 per blood unit) at public facilities.

7. Himachal Pradesh

i. The utilization of untied fund is low, and the state is having high unspent balances. The user charges are being collected in the facilities and amount is deposited in RKS.

ii. All the facilities are maintaining proper cash Books and ledgers are per the guidelines. The expenses are regularly booked in the Cash-Book.

iii. There is no delay in the transfer of funds from State Treasury to the State Health Society, and State to Districts/ Blocks.

iv. State has introduced a manual on supply chain management for Drugs and Medicine.

v. RKS funds are being used in program expenses, despite the programs having sufficient funds. Audit of the RKS were not found regular.

vi. TDS are not being deducted for vendor payments and remuneration for contract staffs.

vii. Facilities should be prompt in Action Taken Report (ATR). It was found that in some facilities, ATRs of CAG audit was not submitted even after eight months.

viii. JSY payment to beneficiary is being made through PFMS. There is delay in payment to the beneficiary with Gramin Bank and Cooperative Banks (Non CBS Branch).

ix. 100% agency registration is completed in PFMS. DBT for JSY beneficiary has started. Although, E-payment to ASHA is not yet implemented and FMR is not being generated through PFMS.

x. Out of pocket expenditure observed by team members on Ultrasound in Solan District during ANC by beneficiaries amounting to Rs. 300/- to Rs. 1000/and on Drugs ranging from between 1400 to Rs. 3000/-

8. Jammu & Kashmir

i. There is delay of 3-4 months in transfer of funds from State Treasury to SHS. Fund disbursement to VHNCs is not in place from last 3-4 years

ii. All the payments towards ASHA incentive and JSY beneficiary are being paid through DBT using PFMS.

iii. E-transfer at all facilities is followed and no cash transactions are taking place.

iv. The registration of Agencies on PFMS portal has been done.

v. The records of District Cold chain and District Warehouse

are managed in the best way possible.

vi. Financial training at different levels is the need of the hour. Some posts are vacant at district and block level.

vii. DHS and all RKS are registered under Society Act but Registration Certificate is expired and not renewed since 6 years

viii. The Agency registration has been completed almost at all the levels but the expenditure filing towards Non-DBT payments through PFMS portal has not been initiated yet.

ix. Lack of awareness about maintenance of various accounting registers.

x. Authenticated support document was not in place while making the payment towards RBSK Vehicle.

xi. No uniformity is followed in keeping the records across districts and blocks, due to lack of stationery material.

xii. Female Sterilization payment voucher was not available at visited District Hospital.

xiii. No proper monitoring on the payment made towards Mobility Support.

xiv. Salary disbursement against performance appraisal is not in place.

xv. It has been observed that the patients are not getting full support in-terms of medicines, Blood bank etc., as in some cases they have been advised to purchase the medicines from market all contributing to high out of pocket expenditures.

xvi. Compliance on the Statutory Audit and Concurrent Audit are not followed.

xvii. Most of the CHCs and PHCs have not followed the rules of Income Tax under tax deduction at sources (deductions made in the last month of the financial year).

xviii. There was delay of 5-6 months towards JSY payment to beneficiaries in both the district for the FY 2016-17.

9. Jharkhand

i. Vacancies in accounting positions at block level needs to be addressed. The State needs to provide refresher and updation trainings to its accounting staff at all levels on regular basis.

ii. Upon receipt of funds from the GoI, the State Treasury transfers the funds to SHS Bank A/c via RTGS. From SHS onwards, the funds to all the facilities at District, Block, Sub-centre and Village level are transferred via e-transfer.

iii. Untied funds for FY 2016-17 not released by CHC to VHSNCs during FY 2016-17 in visited centres.

iv. Instances of delay in payments of JSYs were found due to non-availability of bank account details.

v. District ROPs have been disseminated and available with District Health Societies.

vi. In the facilities visited, all programme bank accounts were operated as per the guidelines issued by the Ministry. Dual signatories were available for each such bank account held.

vii. TDS is being deducted at the source. Quarterly returns of such TDS deductions are also being timely filed to the Income Tax Department in prescribed formats i.e. Form 24Q and 26Q.

viii. CAG Audit for the period 2011-16 in the State has been completed.

ix. The Statutory Audit Report for the F.Y. 2015-16 is also yet to be submitted by the State to GoI.

x. The Concurrent Auditors have been appointed by the State in all the Districts for F.Y. 2016-17.

xi. About 77% agencies have been registered under the PFMS portal with pendency at VHSNC level.

xii. All the financial transactions including JSY beneficiary/ ASHA/Contractual staff/ Family Planning Schemes up to the CHC/PHC level are being made through PFMS. Cash books have been maintained manually and were found up to date.

xiii. Bank Reconciliation Statement (BRS) for all the bank accounts have been prepared as on 31.10.2016

xiv. The meetings of District Health Society are conducted at regular basis.

xv. Procurement of drugs without approval from relevant authority was found.

10. Kerala

i. All finance and accounts personnel positions have been filled in the state.

ii. Payment of salaries to NHM contractual staff delayed by 2 months

iii. Duration for transfer of funds from State Treasury to State Health Society Bank Accounts is about 88 days. Time taken by the facilities to receive funds from the SHS/DHS is about 7 days.

iv. Differential financing for allocating untied funds is not being implemented.

v. Utilization certificates are submitted in time by agencies and vendors. KMSCL is not furnishing UCs for last 3 years.

vi. Utilization of funds received under NUHM in state is 65% in up to Sep 2016-17, 95% in 2015-16, and 92% in 2014-15.

vii. Areas of low utilization in 2016-17 were civil works-1%, Training-3%, Procurement of Equipment- 3%.

viii. CAG audit was completed up to 2015-16. Statutory Audit for 2015-16. There is delay in appointment of concurrent auditors. Appointment has been completed only in four districts and State office; appointment in rest of the districts is in progress.

ix. Account books are being maintained correctly and have been updated to date.

x. Direct Benefits Transfer is implemented to JSY beneficiaries. Special software is used for ASHA payments and e-transfer is made. In addition to incentives, ASHAs receive a monthly honorarium of Rs.1500, every two months.

xi. PFMS registration is not fully completed in the state. 62% agencies have been registered because the bank accounts of the VHSNC & SC agencies are with co-operative banks that have not been computerized. Only one district in the state started real time payments. State has also not started filing expenditure in PFMS. All 14 districts are using Tally customized ERP 9 software for accounting purpose. FMR is not generated using PFMS.

xii. No BPL is paying any OOPE for medical expenses, there is no 108/102-ambulance facility available, because of which there is OOPE on transportation.

xiii. The state has not started the process of institutionalization of State Health Accounts (SHA). NHA state nodal officer has not been appointed and state has not proposed funds for conducting SHA in PIP.

xiv. State has RSBY health insurance program called as Comprehensive health insurance scheme (CHIS) and CHIS plus with an extended population, benefit coverage and maximum reimbursement. Total 32.53 lakh households have been enrolled for 2016-17. The administrative cost of operating the scheme is 5% with a claims ratio of 94% in FY 2015-16.

11. Madhya Pradesh

i. Vacancies upto 24% and 41% are reported at the District and Block level respectively for finance and accounts personnel.

ii. Delay on transfer of funds from Centre to state is reported.

State Treasury transfers the funds to SHS via NEFT. From SHS onwards, the funds to all the facilities are transferred through PFMS.

iii. 58.53% of RoP approvals have been released to SHS of which 25.84% has been utilized as on 31.10.2016, however, utilization is 60.28% as on 31.10.2016, when opening balance, Central Release and State share is combined. A very slow pace of utilization under the NCD programme which is only 16.67%.

iv. It is reported that DHAPs is being prepared on the basis of 30% additional funds to High priority Districts. However, RoP approvals disseminated to the Districts are based on the expenditure pattern of the last year.

v. Across the State, no mechanism is adopted to settle the long standing advances. High unspent balance was found to be lying across the State. Staff advances are outstanding from the F.Y. 2005-06.

vi. In all the facilities visited, user charges collected are being deposited in the RKS bank account.

vii. Non submission of Statement of Expenditure for Infrastructure Maintenance.

viii. CAG Audit for the period 2011-12 to 2015-16 in the State has been completed.

ix. The Statutory Audit for the F.Y. 2015-16 has been completed and final report is submitted to GoI after the delay of 3 months.

x. The Concurrent auditor for F.Y. 2016-17 is not appointed so far. The gaps rose in the concurrent audit report of the F.Y. 2015-16 are still persisting.

xi. All the programme bank accounts are operated as per the guidelines issued by the Ministry.

xii. In all the facilities visited, cash books have been maintained both in Tally software and manually and were found up to date.

xiii. Overall implementation of PFMS is very good throughout all the facilities. 95% agencies have been registered under the PFMS portal. All the financial transactions including JSY beneficiary/ ASHA/Contractual staff/ Family Planning Schemes up to the CHC/PHC level are being done through PFMS portal.

xiv. Sufficient funds have been released but due to lack of clarity of activity, jeopardise the programs. Delay in dissemination of the approvals to the districts. Before receiving the approvals the Districts incurred the expenditure on the basis of last year's approvals for all the running activities or State sanctioned the approvals for a particular activity.

xv. Janani Suraksha Yoyana (JSY) incentive at DH Civil Surgeon is pending for 60 patients for the FY 2016-17 and Sub Centre Makodia Rundi is kept on pending for 463 patients for FY 2014-15 to 2015-16.

12. Maharashtra

i. Cash books are signed by a single person in all the peripherals visited of Nagpur. In Nashik DHS cash book is signed by three persons.

ii. Advances to Staff & peripherals are maintained in Tally. Advances to staffs are also maintained manually, but not to Peripherals, in all the facilities visited.

iii. Most of the Payments are made online in all the Facilities but a few payments are made through crossed cheque.

iv. Cash Books are maintained per bank accounts. But no ledger is maintained at Ramtek SDH in Nagpur District.

v. Audited UCs are submitted.

vi. TDS on remuneration to contractual staff are deducted on annual basis. TDS deducted are deposited & return filed on time.

vii. In Maharashtra, State ROP are distributed among

97 peripherals, includes corporations & councils (through District Health Society) which covers approx. 72% of Total ROP however State itself holds 28% of total ROP.

viii. Out of Rs.88 Crore ROP only Drug procurement & MAS Foundation covers approx. 27% of Total State ROP however expenditure reported in these two components are only 2.5% of approved ROP, which is almost negligible.

ix. In spite of a big difference of ROP between Corporation & Districts Corporation has made approx. 10% expenditure against ROP, Nashik corporation has made Rs.2 crore (approx.) out of its ROP of Rs.5 Crore (approx.) which is almost 40% of its ROP.

13. Nagaland

i. E-transfer is available at all levels. However, timely submission of Utilization Certificates is a challenge. Though DBT has not been implemented.

ii. There is low utilization of funds. This is on account of under-utilization of health facilities as well due to inadequate follow-up on the program activities.

iii. Untied funds were mostly used for procuring stock of medicines and supplies and for ambulance maintenance/ POL in few cases.

iv. There is a delay in release of funds from treasury to the State Health Society owing to which delays in further release to districts were happening.

v. District ROPs are not prepared leading to a disconnect between the demand of funds and final release to districts.

vi. CAG, Statutory and Concurrent audit were done in a timely manner but the reports have not yet been received. Concurrent Audit report is pending since three years whereas the statutory audit report has not been received for the year 2015-16.

vii. PFMS has not been initiated due to network connectivity related issues and manual system being followed. PFMS training needs to be conducted with the banks in the district too.

viii. The Books are well maintained at SHS and DHS.

ix. Out of pocket expenditure on drugs, diagnostics and transport were observed in the districts. OOPE was also observed in the JSSK beneficiaries (in the range of 500 to 1500) due to lack of assured pick up and drop back services.

14. Tamil Nadu

i. All the sanctioned posts are duly filled up to the level of sub-district with respect to Finance and Accounts

ii. The mode of transfer of funds from treasury to State Health Society Account is “Cheque”. All the funds are being transferred from the State to the Districts and Districts to lower periphery via PFMS.

iii. A delay of average. 40-42 days has been observed in the F.Y. 2016-17 from State Treasury to State Health Society Bank Account.

iv. Incentives to JSY beneficiaries are paid through DBT. Payments under JSY are prompt except SDH and GH and the facilities with high delivery load.

v. The State has not implemented banking arrangement guidelines regarding group bank accounts at District level due to which State has been disbursing money activity wise not pool wise.

vi. There is temporary diversion of funds from one pool to other. For drugs and related supplies every facility has a pass book with allocated funds for a year. If a facility runs out of funds, these are transferred from another facility to ensure availability of supplies at every facility.

vii. Overall 39.49% utilization has been reported till Q 2 (2016-17) against the Approvals and Committed Liabilities. Earlier it was only 7.18% till Q1 (2016-17).

viii. No financial monitoring visits were undertaken from the supervisory units to their lower level units.

ix. Office of CAG has taken up the performance audit of NHM from 2011-12 to 2015-16 and reports were placed before governing body in January.

x. Issues with PFMS as conveyed by state are network issues delaying the transactions, bank officials in remote CHC's not familiar with PFMS, inadequate staff trainings.

xi. Books of Accounts are maintained properly at all levels.

xii. No User charges were found in health facilities.

15. Tripura

i. 41 positions are vacant at the State and district level. The State has initiated steps for filling up of the vacant positions but has not been able to do so due to lack of applications received.

ii. There is a delay in transfer of funds. SHS is transferring proportionate funds from SHS to DHS from the available unspent fund.

iii. Allocation of funds to Districts is made on the basis of previous year's actual expenditure not on the basis of programme requirement.

iv. It is found that all the salary transfer & incentives to Asha are done through e-transfer and JSY transfer to beneficiaries are made through Cheque. These transfers are found regular.

v. CAG Audit for the period 2011-16 in the State has been completed. The Statutory Audit for the F.Y. 2015-16 is underway. The Concurrent Auditors for the F.Y. 2016-17 has not been appointed for the State and all the Districts.

vi. TDS is being deducted from eligible payments and are timely deposited. Quarterly returns are also timely filed.

vii. Overall implementation of PFMS is unsatisfactory throughout all the facilities. 67% agencies have been registered under the PFMS portal.

viii. Cash books have been maintained manually and were found up to date. Tally though available with the state is not being used and the state needs to look upon the same.

ix. RKS bodies in all the facilities visited were found registered up to March, 2017. The user charges collected are being deposited in the RKS bank account.

16. Uttar Pradesh

i. There are very few vacant positions in the state for financial staff.

ii. The per capita allocation of funds for High Priority Districts is only 5% more than that of Non-High Priority District.

iii. Funds from the State Treasury to State Health Society bank accounts are being transferred through NEFT/RTGS.

iv. The status of registration of agencies under PFMS has improved by only 1% (i.e. from 83% to 84%) in last one year.

v. District ROPs have been disseminated and available with District Health Societies. BHAP preparation is underway.

vi. CAG Audit for the period 2011-16 in the State has been completed.

vii. The Statutory Audit for the F.Y. 2015-16 has been completed but the final report is awaited from the Auditor.

viii. The Concurrent Audit has been completed up to 30.09.2016 and reports have been finalized.

ix. Cash books are maintained both in Tally software and manually and were found up to date.

x. The user charges collected are being deposited in the RKS bank account.

TOR 9 | QUALITY Assurance

OBJECTIVES

- Review of implementation of the Quality Assurance Programme in the visited States, Districts and Facilities
- Assess preparedness of the States and Districts for roll-out of the Quality Assurance under NUHM
- Assess sustenance of gains made during last year's (2015-16) Kayakalp Initiative
- Review status of Kayakalp in the current year for continuing activities at DH level and extending it to SDHs/CHCs and PHCs
- Review of Status of Biomedical Waste Management in the States, Districts and at Facility level

National Overview

The National Quality Assurance Programme focuses on establishing a system of continuous assessment of health services in terms of Structure, Process and Outcome. Key objectives of the program include finding-out the current gaps, introducing sustainable interventions to address the gaps, and re-assessment, so that beneficiaries are assured of quality in health care- within facility as well as in outreach. Patient satisfaction is also required to be measured regularly. Further, the current approach also nudges the facility to look at the 'improvement' through Plan-Do-Check-Act (PDCA) approach. Since the launch of the programme in the year 2013 end, supportive institutional network at state level and below has expanded gradually in the past few years. However, larger investments in capacity building and operationalisation are required to strengthen the capacity of available support structure to ensure effective supervision, performance monitoring and mentoring.

Reconstitution of State Quality Assurance Committees and District Quality Assurance Committees has been completed in all States. However, operationalisation of State quality assurance units and District quality assurance units is in different stages in the States and UTs. Baseline assessments against the National Quality Assurance Standards have been initiated in all States except in the States of Arunachal Pradesh, Goa, Nagaland, and Telangana. Baseline Assessments for Urban

Primary Health Centres too have been initiated in 10 States (Karnataka, Andhra Pradesh, Uttar Pradesh, Delhi, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Haryana and Odisha) and assessment for 410 Urban PHCs (UPHCs) against UPHC Standards have been completed. However, Patient Satisfaction Surveys are yet to be institutionalized and as many as 13 States (Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Jammu & Kashmir,

Manipur, Meghalaya, Nagaland, Sikkim, Tamil Nadu, Telangana, Tripura and Uttarakhand) are yet to initiate the process. Standard Operating Procedures for various functions have been developed in all States except in Assam, Chhattisgarh, Delhi, Jammu & Kashmir, Maharashtra, Punjab, Tamil Nadu and Tripura. Further, the Key Performance Indicators are being monitored in all States except in Arunachal Pradesh, Assam, Chhattisgarh, Jammu &Kashmir, Meghalaya, Nagaland, Tamil Nadu, and Telangana. While 106 health facilities have undergone state certification; a total of 10 facilities have undergone assessment for the National Certification. Currently a total of 140 external assessors and 1,510 internal assessors are empanelled with NHSRC and SQACs for supporting the NQAS activities.

After launch of 'Kayakalp' initiative in May 2015, the States declared the Awards in District Hospital category last year and in the current year the initiative has been scaled-up to include SDHs, CHCs and PHCs. Under the Kayakalp a total 38 trainings have been conducted.

Key Findings

1. Organisational Structure for Quality Assurance

State Quality Assurance Committee (SQAC) has been constituted in all the States visited during 10th CRM. District Quality Assurance Committee (DQAC) has been constituted in all States for all districts except in Arunachal Pradesh where DQAC is yet to be constituted for Upper Siang and East Siang districts. Functionality of these committees in terms for periodic meeting is still an issue in some States, more so at district level. Only four States (Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh) have been conducting SQAC meetings regularly. The constitution of quality assurance units both at state and district levels is still a challenge in many of States as recruitment of full time professionals, as approved in the States' PIPs, have not been done.

2. Training and Capacity Building

Capacity building of all States visited during CRM has been done (both in NQAS and Kayakalp) with the support of NHSRC, except for Kerala and Chandigarh. These two State/UT have not conducted any trainings pertaining to NQAS and Kayakalp in Financial Year 2016-17.

3. Baseline Assessment of Facilities (Facility Assessment and Gap Analysis)

States have taken initiatives for baselines assessment of its public health facilities) but gap closure activities based on the assessment findings in a time bound manner needs to be initiated. The States also need to develop & intensify supportive supervision of assessed facilities. Assessments have been initiated in 15 States (except Nagaland) but only five States namely Andhra Pradesh, Kerala, Uttar Pradesh, Gujarat and Maharashtra have developed an action plan for gap closure post the assessments.

4. Certification of Facilities

The States have initiated the process of both National and State certifications. However, none of the visited States showed evidence that they would be meeting the commitment made

in the PIPs regarding number of Health facilities, which would be Quality Certified in year 2016-17. Out of total 16 States visited during CRM only two States namely Gujarat and Kerala have completed state certifications and three States (Uttar Pradesh, Gujarat and Kerala) have applied for national certification. Common observation is that progress after Assessment/Gap Analysis is slow in terms of Prioritisation of Gaps, developing Action Plan, implementing measures of ensuring Quality Care (detailed below), closing gaps and preparing facilities for certification

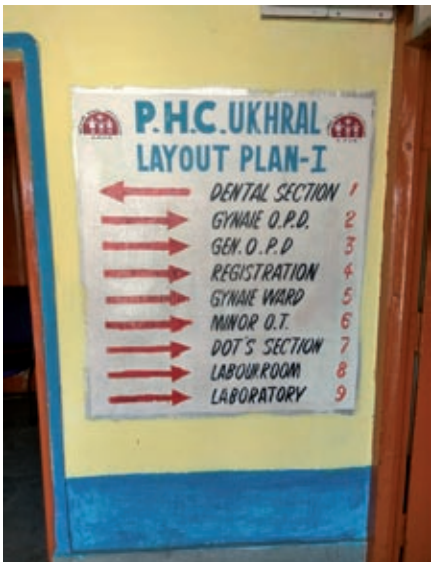
5. Measures for ensuring Quality of Care at Public Facilities

i. Standard Operating procedures (SOP)

SOP's form an integral part of the quality management system. In the visited CRM States SOP's were developed in the some of the facilities of only six States namely Uttar Pradesh, Arunachal Pradesh, Kerala, Gujarat, Jammu & Kashmir and Andhra Pradesh. However, interviewing the staff it was observed that staff was not well versed with SOP's. In the state of Gujarat, the SOP's were developed centrally at the state level and were not customised as per the facility, making it non applicable in many places. Rest remaining 11 States had not even initiated the process of development of SOP's.

ii. Measuring Patient Satisfaction Survey (PSS)

Level of satisfaction of patients visiting a health facility is the litmus test of quality of services delivered. Public health facilities in Bihar, Kerala, Tripura and Madhya Pradesh had developed forms for Patients satisfaction



survey which were filled by the patients but no analysis of the filled forms were done. In Gujarat PSS was not done as the PSS forms provided to the state has not been translated in Gujarati. Only state of Delhi had completed patient satisfaction survey along with complete analysis. In Arunachal Pradesh last PSS was conducted in the year 2012 in District Hospital Pasighat. In rest of the 12 States PSS process has not been initiated

iii. Measuring Key Performance Indicators:

States have progressed considerably well in reporting and analysis of the Key Performance Indicators. Six States namely Madhya Pradesh, Andhra Pradesh, Gujarat, Kerala, Jharkhand, Maharashtra have started monitoring of key performance indicators. Rest of the 10 States are yet to initiate reporting and analysis of KPIs. Andhra Pradesh has developed a dashboard and Jharkhand has started giving

performance incentives to staff based on the indicators. On the positive side, many States have issued enabling order for monthly reporting of Key Performance Indicators.

iv. Bio Medical Waste Management

Bio Medical Waste Management remains a cause of concern, more so with notification of revised BMW Rules on 28th March 2016, the States are still working out modalities of implementation of changes, which the revised rules bring into. It was noted that in majority of visited districts, awareness regarding the new rules is found to minimal. Only in three States namely Uttar Pradesh, Maharashtra, Andhra Pradesh and UT Chandigarh the awareness regarding the new BMW rules was evident among the staff and the implementation as per the new rules was initiated. In Tamil Nadu, Himachal Pradesh and Jharkhand, a well maintained Bio Medical Waste Management System is in place according to BMW rules 1998. Disposal of Biomedical waste was a major concern in States like Arunachal Pradesh, Nagaland, Jammu & Kashmir and Madhya Pradesh as facilities visited were burning the BMW waste. Poor implementation was observed in Gujarat (conflicting posters appeared in the same health care facility (old and new guidelines) and Delhi (mixing of waste).

v. Grievance redressal mechanism for addressing grievances of patients

In Himachal Pradesh grievance redressal mechanism system through toll free no 104 has been initiated but is in nascent stage. No proper mechanism was evident in all the States regarding grievance redressal. Often complaint boxes are seen to be having 'token' presence, and the boxes remain un-opened. On patient interview it was observed that there was lack of awareness among patients regarding grievance redressal mechanism. Orders regarding grievance redressal committees existed but no meetings were conducted for the same.

6. Kayakalp

States have shown a high degree of commitment towards Kayakalp program and are progressing well in the program. Since it's the second year of the program from its launch in 2015 considerable improvements in levels of cleanliness, hygiene and infection control were observed. Andhra Pradesh, Arunachal Pradesh and Himachal Pradesh have declared the Kayakalp awards. Gujarat, Madhya Pradesh and Maharashtra have finished the external assessments and

declaration of awards is pending for administrative approvals. The progress is relatively slow in Bihar, Jammu & Kashmir, Delhi, Tamil Nadu, Jharkhand, Nagaland, Uttar Pradesh and Tripura as the process of internal and peer assessments is still undergoing. Chandigarh has not initiated Kayakalp as there were no ROP approvals

Recommendations

1. Organisational Structures

States need to operationalise the already constituted state and district quality assurance committees by conducting six monthly review meetings at state level and quarterly review meetings at district levels. This will ensure regular follow up of the program as well as other related issues being addressed at the desired level. Recruitment of HR for the Quality Assurance units need to be accelerated.

2. Trainings

Since the launch of the National Quality assurance program and Kayakalp a total of 105 trainings have been conducted. Trainings have been in conducted in all the 16 States visited during 10th CRM with a minimum of at least 2 trainings/state. Hence as of now States are rich in trained manpower in quality assurance and it is recommended that States should start utilising its trained manpower in further trainings and implementation of the program in the state. Trained resources may be used for conducting internal assessments and providing inputs in closing gaps observed at the facility and help them move towards certification process.

3. Going beyond assessment and Gap analysis

A common observation among the visit during 10th CRM is that almost 50%of the States have initiated the assessments but gap closure action plans are yet to be finalised. Hence it is recommended that States should prioritise the identified gaps and develop time bound action plans. Efforts should be made to close the gaps and preparing facilities for National certification.

4. Kayakalp and Other QA activities

i. Cleanliness, hygiene and Infection control:

Since it's the second year of implementation of Kayakalp States should focus on improvements from the previous year in cleanliness of the facilities and infection control as it is one of the major factors which influence patient satisfaction

ii. Bio medical waste management

States should work in removing the ambiguity among the facility staff pertaining to the new revised rules of BMW 2016 and help the facilities in implementation of the new rules. Strict actions should be taken against burning of the biomedical waste. Strengthening of the disposal and storage of biomedical waste should be done.

iii. Infection Control activities

Both Kayakalp and national quality assurance program majorly focus on the infection control activities. Good implementation and stringent vigil on staff may help the States to achieve good infection control practices. States should regularly engage in trainings pertaining to hand hygiene practices, use of personal protective equipment, isolation

precautions, sterilisation, cleaning and disinfection practices.

iv. Conducting patient satisfaction surveys

Operational guidelines for quality assurance provides with a format for PSS both for IPD and OPD along with the methodology of taking the correct sample size. States those who have not developed the format are recommended to kindly utilise the same and start conducting patient satisfaction surveys. Regular analysis and intervals of patient satisfaction surveys should be followed.

v. Reporting of Key Performance Indicators

States require putting a system in place where all healthcare facilities capture, measure and report the KPIs. Analysis of the KPIs is helpful at state, district and facility level for planning and improvement of health facilities.

vi. Grievance Redressal Mechanism goes a long way in providing patient-centric care and building trust of community. Measures for a robust grievance redressal may include installing Complaint/Suggestion Box, Dedicated Helpline, Open meetings etc. All complaints need to be resolved within a stipulated time-bound manner and feedback provided to the complainant.

vii. Audits

Periodic and regular Prescription, Medical and Death audits should be carried out at all levels of health facilities followed by analysis with corrective and preventive actions based on findings.

viii. Internal and External Quality Assurance Program including regular monitoring, implementation of housekeeping checklist, Daily round of the facility by Facility In charge, Matron/ Head nurse and Hospital Manager, conducting internal assessment at periodic intervals, mock drills, for Fire and other disasters, validation of lab tests, calibration of equipment, monitoring of radiation exposure by TLD badges etc. need to be done on regular basis.

ix. AERB Approvals

The X-ray departments of the facilities including Portable X-Rays and C-Arm need to be realigned as per AERB guidelines as it will help in preventing radiation hazard.

x. Standard Operating procedures

SOP's are responsible for maintaining uniform process throughout the facility and adherence to the protocols in case of ambiguity. It is suggested that state should develop easy to understand, crisp and implement SOP's in vernacular language.

State findings

1. Andhra Pradesh

Quality Assurance

i. Quality assurance committees and units have been constituted both state and district level, however meetings are not conducted regularly. As last SQAC meeting was conducted in September 2015 and only 4 districts out of 13 have conducted DQAC meetings

ii. Recruitment of HR is completed which includes 13 district quality consultants and 13 district quality

managers but HR recruited is being utilised to support in the medical colleges and can devote very less time for quality assurance.

iii. The State has committed for National certifications 26 facilities i.e. 9 DH, 2MCH, 14 area hospitals and 1 CHC -17. However no progress has been done in the same.

iv. The state has initiated monitoring Key Performance indicators and conducting clinical audits in the facilities which are being regularly monitored by a centralised dashboard.

v. Baseline assessments of 26 facilities have been completed. However time-bound activity plan for Gap closure at each of the facility needs to be developed. The State needs to develop & intensify supportive supervision of assessed facilities

vi. State has not yet applied for national certification.

vii. BMW Guidelines 2016 have been circulated to the facilities. Segregation of waste is being done per protocol. Waste from higher facilities is collected for treatment and disposal is done at identified hubs; while these are being done at the facility itself in PHCs.

viii. Urban PHCs are being upgraded under the CMU-PHC Initiative and implementation of the Quality standards for UPHCs will be done.

ix. One Service provider and One NUHM training has been imparted in the state.

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. Internal and Peer of all District Hospitals, SDH/CHC, and PHC completed.

iii. External assessment pending for 1314 facilities

2. Arunachal Pradesh

Quality Assurance

i. Quality assurance committees and units have been constituted only at state level.

ii. Recruitment of HR is completed which includes one state consultant, one state nodal officer and one program assistant

iii. The State had committed for both State and National certifications of 5 facilities but no progress has been made in this area.

iv. State has made progress in conducting Medical audit and Death audit at one of the selected facilities,

v. SOP's were available at point of use.

vi. State has not yet initiated monitoring of KPIs

vii. No progress has been made in the area of conducting patient satisfaction survey. Last survey was conducted in 2012.

viii. Slow progress in conducting assessments as only one Baseline assessment has been conducted till date.

ix. State has not yet adopted the new revised BMW rules 2016. Staff has poor knowledge of segregation of waste. Burning of BMW was evident.

x. Two days master Swachh Bharat Training has been imparted in Arunachal Pradesh by RRC-NE

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. Internal and Peer assessment of all facilities has been completed.

iii. External assessment pending.

iv. Result declaration is pending at state level.

3. Bihar

Quality Assurance

i. Quality assurance committees have been constituted both

state and district level. However no meeting has been conducted till date at state level

ii. Recruitment of HR is completed at state level and is under process at district level.

iii. Hospital infection control committee is in place and is functional.

iv. No progress has been made in the quality improvement activities like conducting audits, and monitoring Key Performance Indicators.

v. Patients satisfaction surveys forms were evident but no analysis has been done for the same.

vi. Facility level assessments of total 69 health facilities i.e. (11 DH, 5 SDH, 7 RH, 4 CHC, 40 PHC has been completed, however no roadmap for gap closure actions has been developed.

vii. The State had committed for National certifications 17 DH and 10 SDH but has no progress has taken place in this.

viii. One service Provider, One internal assessor and two NUHM trainings has been imparted to the state.

Kayakalp

i. State has declared Kayakalp awards to 4 DH (Banka, Siwan, Khagaria and Motihari) and one CHC (Sambhooganj, district Banka). However the award money is yet to be transferred.

ii. Award money for PHC/APHC has been allocated to districts.

iii. Two trainings of external assessor Kayakalp has been imparted to the state.

4. Chandigarh

Quality Assurance

i. Quality assurance committees have been constituted only at UT level. However no meetings have been conducted till date.

ii. Recruitment of HR is not done. One quality consultant post is vacant from three months and no hospital managers in facilities.

iii. The UT has committed for National certifications of 2 facilities i.e. 1 District Hospital and 1 Community health Centre.

iv. No progress has been made in the quality improvement activities like conducting audits, patient satisfaction surveys and monitoring Key Performance Indicators.

v. Slow progress in conducting assessments as only one Baseline assessment for District Hospital has been conducted till date.

vi. Awareness regarding BMW 2016 done and implemented

vii. No Nodal officer has been designated for handling quality assurance under NUHM

Kayakalp

i. No budget has been approved for the UT regarding Kayakalp.

5. Delhi

Quality Assurance

i. Quality assurance committees have been constituted both state and district level, however meetings are not conducted regularly. As last SQAC meeting was conducted in 2013 and DQAC meeting for Shahdara district in Oct 2016.

ii. Quality assurance units have not been constituted yet both at district and state level.

iii. Recruitment of HR is complete at state level but at district level no recruitments are been done.

iv. The State had committed for National certifications 6 District Hospitals and 265 Primary Urban Health centres. However state has not applied for any.

v. No progress has been made in the quality improvement activities like conducting audits, and monitoring Key Performance Indicators

vi. Patient satisfaction surveys have been conducted at facilities.

vii. All radiology departments are as per the AERB guidelines and hold AERB approvals.

viii. Awareness trainings regarding BMW 2016 done but not implemented at facilities.

ix. 2 NUHM trainings and one Internal assessor has been imparted to state

Kayakalp

i. State and District level Award Nomination Committee Assessment committees have been formed.

ii. The process of assessment is very slow in state. In Kayakalp 37 DH level hospital and 265 U-PHCs needed to be assessed, however till date only 5 hospitals have completed internal assessment

iii. One awareness and one Swachh Bharat Abhiyaan have been conducted in the state.

6. Gujarat

Quality Assurance

i. Quality assurance committees and units have been constituted both at state and district level and regular meetings have been conducted.

ii. Hospital infection control committees are in place and functional.

iii. State has not proposed for HR under quality assurance and is utilising the staff from regular cadre.

iv. In most of the facilities, the revised guidelines for biological waste management 2016 are not known. In addition to that, there were cases when conflicting posters appeared in the same health care facility (old and new guidelines).

v. The State had committed for 50 facilities for National certifications and 200 facilities for state certification.

vi. The state has initiated monitoring Key Performance indicators and conducting clinical audits in the facilities which are being regularly monitored.

vii. Patient satisfaction survey has not been conducted yet due to non-availability of patient satisfaction survey forms in Gujarati.

viii. State has developed centralised SOP's for all facilities, however they are difficult to implement at the user end. The SOP's developed are lengthy and complex due to which staff does not have sufficient time to read them

ix. Nodal officer for quality assurance under NUHM has been appointed and 8 U-PHCs under Rajkot Municipal Corporation have received state certification

x. One Service Provider Training has been imparted to the state.

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. Internal, Peer and external assessments of all District Hospitals, SDHs/CHCs, and PHCs completed.

iii. Result declaration is pending at state level.

7. Himachal Pradesh

Quality Assurance

i. Quality assurance committees and units have been constituted both state and district level, however meetings are not conducted regularly.

ii. State has not yet constituted Hospital Infection control committee.

iii. Recruitment of HR is complete which include one full time Quality Assurance Officer as a nodal person for Quality Assurance Programme. She is supported by State Consultant Quality Assurance and State admin cum Programme assistant.

iv. The State have committed for National certifications 4 facilities and state certification

of 6 facilities but no progress in has been made by the state.

v. State have initiated prescription in Arki and Dharampur Civil Hospital visited at Solan district, but sample size was grossly inadequate(9 out of 2762 OPD prescriptions)

vi. State has not initiated monitoring of Key Performance indicators and has neither conducted patient satisfaction survey.

vii. For grievance redressed state has initiated a Toll free number (104) but the project is at nascent stage.

viii. External quality assurance program for labs not initiated.

ix. No facility in the state has an AERB approval for X-ray department

x. State has initiated internal assessment of all District Hospitals. Action planning after traversing assessed gaps and towards the certification was seems to be very slow

xi. State has an well maintained Bio Medical Waste Management System in place but according to 1998 rules.

xii. One service provider and one internal assessor's have been imparted to state.

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. State has declared Kayakalp award for all DHs, CHCs and PHCs after completing entire process like internal, peer and external assessment of the facilities for FY 2016-17 on 18th October 2016.

iii. PHC awards declaration for six districts is still pending

8. Jammu & Kashmir

Quality Assurance

i. Quality assurance committees and units have been constituted both state and district level, however no meeting has been conducted till date. Hospital infection control committee has been formed and is functional.

ii. The State had committed for National certifications 4 facilities i.e. 2 DH and 2 CHC but has not applied yet.

iii. Detailed departmental SOPs were available at point of use in LR, OT, ICU and Labs.

iv. No progress has been made in the quality improvement activities like conducting audits, patient satisfaction surveys and monitoring Key Performance Indicators.

v. State has not yet adopted the new revised BMW rules 2016. Staff has poor knowledge of segregation of waste. Burning of BMW was evident.

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. State has completed the internal assessment of all facilities. Peer assessments need to be initiated. One external assessor Kayakalp training has been imparted

9. Jharkhand

Quality Assurance

i. Quality assurance committees have been constituted both state and district level, however meetings are not conducted regularly.

ii. The State has not yet constituted Hospital Infection control committee

iii. HR recruitments for quality assurance units both at state and district level are pending.

iv. The State has committed 14 selected for state certification and 5 for national certification but has not applied for certification.

v. The state has initiated monitoring Key Performance indicators.

vi. No progress has been made in the quality improvement activities like conducting audits, patient satisfaction surveys empanelment with EQAS, AERB approvals and formation of SOP's.

vii. Facility level assessments have been conducted for 23 District Hospitals but no further actions regarding gap closure have been undertaken.

viii. One service provider and one internal assessor training have been provided to the state.

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. Progress of Kayakalp is very slow as state has still pending internal assessments and peer assessments. At the time of visit only 27 facilities out of 553 had undergone internal assessments.

10. Kerala

Quality Assurance

i. Quality assurance committees and units have been constituted both state and district level and meetings are conducted regularly.

ii. State has constituted Hospital Infection control committee and meetings are conducted regularly.

iii. No additional HR is recruited as state is utilising it existing HR from the regular cadre.

iv. State has committed for State Level Certification for total 28 facilities i.e. 14 District Hospitals and 1 PHC & 1CHC in each district and National Level Certifications of 14 DH.

v. State has till now applied for national certification for 2 CHCs out of which one has received certification with conditionality and the results for second is pending.

vi. State certification of 4 facilities i.e. 1 DH, 2 CHC and 2 PHC has been completed

vii. Facility level assessments of total 44 health facilities has been completed, however no roadmap for gap closure actions has been developed.

viii. Quality improvement activities like conducting audits, patient satisfaction surveys, SOP formation and monitoring of KPI have been initiated but progress is slow.

ix. AERB approvals obtained only for 4 facilities in Kollam where as there are 6 facilities with X ray equipment.

x. EQAS for labs currently done for NABH accredited facilities and is in plan for those going for National Quality Assurance Certification.

xi. Major concern in the bio medical waste management is storage of the waste. As there is minimum 3-7 days gap between waste generation and transportation.

xii. Baselines assessment of UPHCs is completed and patient satisfaction forms have been introduced.

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. State has complete internal assessment for all facilities.

iii. Peer and external assessment could not be initiated due to unavailability of funds.

11. Maharashtra

Quality Assurance

i. Quality assurance committees have been constituted both state and district level. However no meeting has been conducted till date at state level. At district level 75 meetings have been conducted by DQAC.

ii. The State has constituted Hospital Infection control committees and meetings are conducted regularly.

iii. Recruitment of HR is under process, as out of 6 sanctioned positions 2 positions are still vacant.

iv. The State have committed for both State and National certifications total 591 facilities which include 23 DH, 467 PHC, 100 SDH and 50 RH. However progress is very slow and no application has been received till date

v. Baselines assessments has been completed for all facilities in district Nagpur and Nasik and gap closure action plan has been prepared

vi. The State has initiated monitoring of KPIs in all districts.

vii. Quality improvement activities like formulation of SOP's, conducting audits and patient satisfaction survey has not been initiated.

viii. No single lab has joined EQAS. Out of total 380 X-Ray Machines available at all Districts 214 machines are AERB approved.

ix. BMW Guidelines 2016 have been circulated to the facilities. Segregation of waste is being done as per the revised guidelines

x. Essential medicines were available at point of use.

xi. The State is making a steady progress under the NUHM. 103 UPHCs have been selected from 23 corporations for NQAS. Necessary orders and circulars have been sent to districts. HR recruitment under NUHM for undertaking QA activity including NQAS assessment at facility is pending for administrative approvals.

xii. One service provider training, one training on thematic area infection control and two NUHM trainings have been imparted to the state

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. State has completed external assessments for DH, CHC and SDH and the result is awaiting administrative approvals.

iii. Internal assessment for PHCs is under process.

iv. One Swachh Bharat Training and one External assessor Kayakalp has been imparted to state.

12. Madhya Pradesh

Quality Assurance

i. Quality assurance committees and units have been constituted and functional at state level but not districts.

ii. Recruitment of HR at district level has not been done.

iii. Patient satisfaction survey has been conducted but analysis is still pending.

iv. None of the facilities have the radiology departments approved by AERB.

v. An external quality assurance program for labs has been initiated and enrolment for both biochemistry and haematology tests has been done with AIIMS New Delhi.

vi. Baseline assessments of 32 District Hospitals have been completed. However time-bound activity plan for Gap closure at each of the facility needs to be developed. The state needs to develop & intensify supportive supervision of assessed facilities.

vii. State has three hospitals namely DH Bhopal, DH Shivpuri and DH Satna ready to undergo assessment for National Certification but is yet to apply for National Certification.

viii. Monitoring of Key Performance Indicators has been initiated in 30 districts.

ix. State has not developed any SOP's for the critical departments.

x. Infection control protocols are not followed in pathological labs.

xi. Disposal of biomedical waste is a major concern as there is delayed or no collection of biomedical waste from the facilities. In the visited CHCs,

burning of BMW was found for disposal as there was no agency to collect the BMW. In DH Ratlam, BMW was dumped in open.

xii. 3 NUHM trainings and 1 Service Provider Training has been imparted in the state.

xiii. The State had committed for National certifications of 15 Health facilities (3 District Hospitals, 2 Civil Hospitals, 5 Community Health Centres and 5 PHCs in the FY 2016-17. But the progress towards achieving these targets has been slow.

Kayakalp

i. Kayakalp internal assessment was done at some of the facilities. However, the score for some of facility was below 70.

ii. State and District level Award Nomination Committee Assessment committee formed.

iii. Internal, Peer and External Assessments of all District Hospitals, SDH/CHC and PHC completed.

iv. Result declaration is pending at state level.

13. Nagaland

Quality Assurance

i. Quality assurance committees and units have been constituted both state and district level, however meetings are not conducted regularly.

ii. HR recruitments for quality assurance are pending.

iii. The State had committed for 2 facilities for National certifications and 11 facilities for state certification.

iv. The State has not applied for national certification and neither conducted any state certification.

v. Awareness about the new revised BMW rules 2016 among facility staff is very low.

vi. The State has not conducted any baseline assessments

vii. Quality improvement activities like conducting audits, patient satisfaction surveys, SOP formation and monitoring of KPI have not been initiated.

viii. State has not empanelled labs under EQAS.

ix. Not even a single X-ray facility has received an AERB approval

Kayakalp

i. State and District level Award Nomination Committee is formed.

ii. State has initiated assessments under the Kayakalp program and is still under the process of completing internal and peer assessments.

iii. External assessments are pending.

14. Tamil Nadu

Quality Assurance

i. Quality assurance committees have been constituted both state and district level, however meetings are not conducted regularly.

ii. State has not constituted hospital infection control committee.

iii. No HR recruitments pertaining to quality assurance has been done.

iv. The State had committed for National certifications 7 DH and for State Certification: 7 DH, 80 CHC/SDH, however no progress has been made so far.

v. No progress has been made in the quality improvement activities like conducting audits, patient satisfaction surveys and monitoring Key Performance Indicators.

vi. SOP's are not available at point of use.

vii. All facilities except for Sub-Divisional Hospital (SDH) Nanguneri had AERB approval for X-ray equipment.

viii. State has an well maintained Bio Medical Waste Management System in place but according to 1998 rules, 2016 rules not uniformly implemented.

ix. Essential medicines were available.

x. One Internal assessor and One NUHM trainings has been imparted to the state.

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. The Kayakalp Programme has been initiated at the District hospital level only and is yet to expand to CHCs, PHCs and UPHCs.

15. Tripura

Quality Assurance

i. Quality assurance committees and units have been constituted both state and district level, however meetings are not conducted regularly.

ii. Hospital infection control committee has not been constituted.

iii. HR recruitments are complete at state level as there is one state consultant. State has not proposed for any HR at district level and is utilising the existing DPM's.

iv. The State had committed for 4 DH for National certifications but has applied for even as single hospitals for national certification.

v. State has conducted first round of assessments for all facilities but gap closure actions have not been prepared.

vi. Patient satisfaction survey is initiated at district levels but analysis is not done

vii. Quality improvement activities like conducting audits, SOP formation and monitoring of KPIs have not been initiated.

viii. State has not empanelled labs under EQAS.

ix. Not even a single X-ray facility has received an AERB approval.

x. Awareness about the new revised BMW rules 2016 among facility staff is very less.

Kayakalp

i. State and District Level Award Nomination Committee and Assessment committee formed.

ii. State has initiated assessments under the Kayakalp program and is still under the process of completing internal assessments.

iii. Peer and External assessments are pending.

iv. One Swachh Bharat Abhiyaan training has been imparted to the state.

16. Uttar Pradesh

Quality Assurance

i. Quality assurance committees have been constituted both state and district level and meetings are conducted regularly.

ii. HR recruitments are under process in the state. In the districts visited one district level and one sub divisional level HR with program assistant were available.

iii. State has committed for total 413 facilities for national certification which include DWHs – 59, DCHs – 26, DHs – 68,CHCs - 136,PHCs – 116 and Others- 8. However, progress towards certification is slow.

iv. Till now only one District Hospital has been awarded certification with conditionality.

v. Baseline assessments for all facilities have been conducted and gap closure action reports were available.

vi. Awareness and implementation regarding BMW rules 2016 is good. The visited districts had made changes pertaining to the new rules.

vii. Essential medicines were available in the facilities.

viii. Progress under Quality improvement activities like conducting audits, patient satisfaction survey, monitoring KPIs is very slow and not uniform in all facilities.

ix. SOP's were available at point of use.

x. One awareness and one internal assessor training is imparted to state

Kayakalp

i. State and District level Award Nomination Committee Assessment committee formed.

ii. Awards for district hospitals have been declared.

iii. Internal and peer assessments for PHCs and CHCs are still undergoing.

iv. Two trainings on External assessor's Kayakalp have been imparted to state.

TOR 10 | NATIONAL URBAN Health Mission

OBJECTIVES

- Review of NUHM implementation, vulnerability mapping, integration of NUHM activities with NRHM, RCH, Disease control programs and convergence mechanisms at various levels.
- Oversee the adequacy and service delivery of UPHCs and UCHCs, reporting of urban facilities in HMIS/MCTS, constitution of RKS and untied fund utilization.
- Review the community outreach services, UHND functions, MAS formation, status on ASHA selection and training, and involvement of urban local bodies.
- To review the status QA activities in urban health facilities under NUHM.

The National Urban Health Mission aims to provide primary healthcare services to the urban population, with a dedicated focus on the urban poor and vulnerable population. Launched in 2013, the uptake and performance of the urban health services have consistently improved over the last few years.

Implementation of the Mission has been accelerated in the year 2016, as States have better understanding and clarity around the Mission. There is enhanced awareness and sensitization towards the urban health scenario in the States and ULBs. States have progressed in terms of infrastructure development and renovation of UPHCs, establishment of urban health program teams at the state level, GIS mapping of cities, organizing UHNDs and special outreach camps and recruitment of urban ASHAs.

However, there are several areas of improvement that continue to require attention, even in well performing States. While most of the cities have completed mapping of urban slums (78%), mapping for urban health facilities has been completed in 57% cities, and vulnerability mapping in only 29% of cities. In most of the States service delivery structures such as UPHCs have been established along with strengthening of the existing structures. While 74% UPHCs sanctioned under NUHM have been operationalized in government or rented buildings,

the minimum staff and service package is yet to be put in place in many States. Recruitment has also been slow in most of the States making the implementation overall progress slow. Overall 55% clinical &paramedical staff and only 59% program management staff is in position. The reasons of slow recruitments are mainly lengthy process of recruitment, salary issues and unavailability of personnel.

The selection of Urban ASHAs has been done in most of the States except Himachal Pradesh, Tamil Nadu and West Bengal. MAS formation has been slow in most of the States, and so far, only 46% MAS has been created, out of which around 50% have been oriented.

Convergence among urban health stakeholders, particularly between state health departments and ULBs is a major area for improvement, towards which the States need to work diligently. Convergence from the state level down to the community level, among front line workers of various programs is essential for NUHM's success.

Better convergence and establishment of institutional mechanisms will also enhance timely financial utilization. Low utilization has been observed in Andhra, Bihar, J&K, Delhi, Maharashtra and Madhya Pradesh whereas good level of fund expenditure was reported in Gujarat (76%), Kerala (65%), Tamil Nadu (76%). Many States such as Andhra Pradesh, UP, Chandigarh have entered into Public Private Partnerships to extend services where it would be otherwise difficult.

Key Findings

1. Planning & Mapping

Vulnerability mapping has been completed in Gujarat, partially completed/underway in Jharkhand and Tripura and not been started in Nagaland, Bihar, Andhra, Himachal, Jammu &Kashmir and Kerala. GIS mapping has been completed in Chandigarh, Delhi, Gujarat, Uttar Pradesh and Madhya Pradesh and not done in Nagaland, Andhra, Arunachal Pradesh, Jammu &Kashmir, Kerala, and Maharashtra. States such as Gujarat and Madhya Pradesh have done household surveys to understand the profile of the target population, while Nagaland is planning to begin this exercise soon. Slum mapping has been completed in Arunachal Pradesh, Chandigarh, Gujarat, Delhi, Jammu &Kashmir, Maharashtra, and is in process in Bihar. It is yet to be initiated in Andhra Pradesh, Himachal Pradesh, and Kerala. Madhya Pradesh has conducted a baseline survey of health status and utilization of health care facilities by the urban population living in both slum and non-slum households of 28 cities.

2. Institutional Arrangement & Program Management

While the state level institutional arrangements such as establishment of SPMU, coordination & convergence committees and incorporation of additional members in the governing body have been done in most States, the establishment of district level arrangements is still lagging. In many States, the ULBs are still to take up the implementation of NUHM at city level through CPMUs. Convergence with ULBs was found to be weak in Andhra Pradesh, Delhi, Jammu & Kashmir, Maharashtra and Uttar Pradesh. However, Chandigarh and Kerala demonstrate good examples in terms of ULB collaboration.

3. Infrastructure

UPHCs in Delhi, Gujarat were reported to be established within or near slums. Infrastructure works are in process for new constructions and renovations in many States. Chandigarh, Gujarat, Kerala, and Maharashtra reported good infrastructural condition of UPHCs. While in Tamil Nadu infrastructure work is on track, it is slow in Himachal Pradesh, Nagaland, Bihar, Jammu &Kashmir and Madhya Pradesh as reported. In Bihar and Jammu & Kashmir, most of the UPHCs were functioning in rented premises. Acquiring land in crowded urban areas near slums was a major challenge cited by many States as a reason for delay in new constructions. In many States, even the land is yet to be identified for some UPHCs.

4. Human Resource

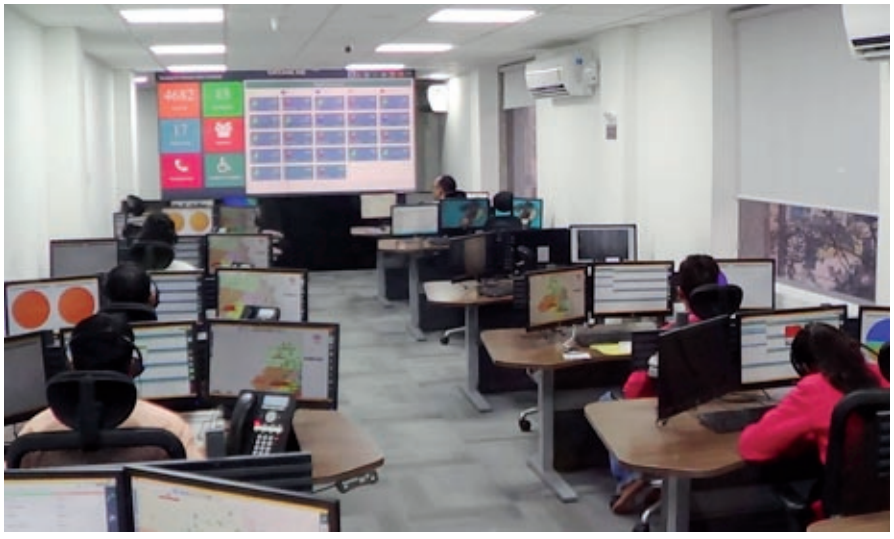
Good recruitment process was reported in Kerala, Gujarat, Tamil Nadu, Jammu & Kashmir, and Chandigarh while in Uttar Pradesh, Madhya Pradesh and Maharashtra, programme and clinical staff has more than 50 percent vacancies. While there is human resource shortage in some States on one hand, on the other there is underutilization of recruited staff like in Arunachal Pradesh (where all staff has been recruited but OPD footfall is low). Recruitment of both programme and clinical staff under NUHM has been difficult owing to low salaries, reluctance to work during evening shifts, unavailability of trained personnel in smaller towns, and slow recruitment process at the state level. States such as Kerala and Tamil Nadu have adequate human resource, but face high attrition rates. When a workforce is in perpetual transition, it is difficult to ensure good levels of training in the staff. High attrition is seen mainly among medical officers, who join NUHM as a stop gap arrangement while waiting for admission to post graduate studies or for seizing better career opportunities in near future.

5. Service Delivery

Range of services provided by UPHCs is still limited with most States not having incorporated services under various Disease Control Programs. NCD services were conspicuous by their absence in most States at the UPHC level, except for Tamil Nadu, Kerala and Chandigarh. Lab services were inadequate in Maharashtra and Jharkhand. Inconvenient OPD timings were an issue as reported

from Tamil Nadu, Kerala, Gujarat, Himachal Pradesh, Jharkhand with UPHCs operating between 9 to 5 pm, thus excluding the working population from availing the services. In Kollam (Kerala) UPHCs were functional until 8 pm, with upto 100 OPD cases per day.

Lack of essential equipment (Maharashtra) and availability of non-necessary equipment (Jkarkhand and Madhya Pradesh) was also reported. Delhi's Mohalla clinics demonstrated good utilization of services, although they have human resources deputed from previously well -functioning facilities.



6. Outreach

Efficient micro planning of UHNDs was observed in Gujarat, Nagaland, Bihar, Maharashtra, Uttar Pradesh, Tripura and Tamil Nadu, with UHNDs held regularly at designated venues. Outreach activities were irregular as observed in Arunachal Pradesh, Jammu & Kashmir, Delhi (due to pending approvals). There was lack of clarity between UHND & special outreach sessions among staff in Madhya Pradesh and in Andhra Pradesh, the staff was not clear about their roles after the introduction of e-Vaidya model of running UPHCs under PPP mode

7. Community Processes

Adequate numbers of urban ASHAs were available as observed in Delhi, Andhra Pradesh, Bihar, Gujarat, Jammu &Kashmir, and Maharashtra. In Delhi, most ASHAs have also been trained up to module 6 & 7. Mahila Aarogya Samitis have been constituted in Madhya Pradesh, Gujarat, Tripura and Andhra Pradesh, formation is underway in Delhi, Jammu &Kashmir, Nagaland and Tamil Nadu, and accounts are yet to be made functional in Andhra Pradesh and Nagaland. Bihar and Chandigarh have been struggling with MAS formation, and Kerala also plans to channelize the existing Kudumbashree groups as MAS groups. In Maharashtra, MAS formation is to be undertaken by NGO as reported. Gujarat reported good record keeping of expenditures by MAS.

8. Quality

State, district and facility level committees for implementing Quality Assurance programme have been formed in Delhi, Bihar, Kerala and Gujarat. In Bihar and Chandigarh, progress on quality assurance is lagging as NUHM officials have not been inducted into Quality Assurance Committees. In Andhra Pradesh, Urban PHCs are being upgraded under the CM UPHC Initiative and Quality Standards will be put in place. In general, it was observed that quality guidelines were not being implemented in Maharashtra, Bihar, Uttar Pradesh and many other States. Inadequate compliance of BMW management guidelines was also reported from Jammu & Kashmir, Delhi, Kerala, and Maharashtra.

9. PPPs

A wide contrast in the area of services is observed in the uptake of PPP mode by States. Andhra Pradesh has outsourced the management of all its UPHCs to private partner Apollo, Chandigarh has also entered into three different PPPs (diagnostic facilities for MRI & CT, e- health centre and laboratory services). Gujarat has been engaged in a longstanding PPP for treatment of Thalasemmia

patients with the Red Cross Society. States have also been involving NGOs to get assistance in NUHM implementation such as Maharashtra where NGO Sneha is providing support for MAS formation. Uttar Pradesh has entered into a partnership with private sector for providing diagnostic services.

10. Finance

Low expenditure has been observed in Andhra Pradesh, Bihar, Jammu &Kashmir, Delhi, Maharashtra and Madhya Pradesh whereas good fund expenditure was reported from Gujarat (76%), Kerala (65%), and Tamil Nadu (76%). Apart from actual low expenditure, low utilization of funds has also been a result of incorrect booking as in case of Arunachal Pradesh, where staff salaries were being paid from NRHM accounts. Fund utilization has also been low due to delay in formation of RKS for UPHCs and delay in transferring funds to them. In Jammu &Kashmir, RKS are non-functional, and RKS have not been constituted in Kerala and Madhya Pradesh.

Recommendations

1. Institutional arrangements such as establishment of state, district and city level implementing teams must be put in place as the first step.

2. GIS mapping for all cities is a must and household based surveys may be conducted, if resources permit. Facility based HMIS reporting should be started for all UPHCs.

3. States must continuously engage with ULBs to elicit active participation and develop role clarity in the implementation process. States/ULB must coordinate with slum stakeholders to acquire land and establish UPHCs.

4. UPHCs must be developed as platforms for integration of all National Disease Control Programs where all primary healthcare needs can be addressed. Convenient OPD timings need to be decided for the target population, with adequate follow up and drug dispensation processes. Further, Labour rooms in UPHCs, where-ever present, must adhere to the protocols of infrastructure and service delivery as defined in the MNH Toolkit.

5. Functional Laboratory with provision of essential diagnostic tests at the UPHC needs to be looked upon on priority. Focus on Optimum utilization of Mother Laboratories needs to be done. Equipment gap analysis should be done to ensure rational placement and utilization of equipment.

6. To maintain continuum of care it is recommended that UPHCs be linked with higher centres of care and the referral facilities identified for UPHCs must be as per time to care approach.

7. Establishment of Rogi kalyan Samitis and Mahila Aarogya Samitis and release of funds to them should be expedited as it is a major reason for low utilization of funds. NGOs may be engaged for recruitment of ASHAs and formation of MAS.

8. States must identify the specific causes of low recruitment, attrition and administrative delays in recruitments and rational

deployment of HR at the UPHCs.

9. Appropriate capacity building and orientation sessions for the DPMs and District Urban Health Coordinators on city health planning, mapping & listing and orientation of ASHAs & ANMs on vulnerability mapping needs to be done.

10. The MoUs for PPP arrangements must define the responsibility of the private partner, and a framework to monitor performance of PPPs including defined time bound deliverable and measurable outcomes.

11. Guidance and handholding of district and corporation on NUHM is required from the States, especially on financial expenditures.

State Findings

1. Andhra Pradesh

i. Planning & Mapping

Mapping of the slums and slum like settlements and vulnerability assessment is yet to be undertaken.

ii. Institutional Arrangement &Program Management

Unlike the rural areas, convergence with other departments and ULBs/Municipal Corporation was found to be very weak. In Kadapa district, the Municipal Health Officer had no involvement in functioning of UPHCs.

iii. Infrastructure

There was a network of UPHCs in the state prior to the launch of NUHM and there are currently 222 UPHC managed by NGOs. District officials were unware about the actual details of mode functioning of e-UPHCs by the new vendor (Apollo) and their role in managing the e-UPHCs.

iv. Human Resource

Existing UPHCs are equipped with 1 MO, 1 Community Organizer, 2 ANMs,1 MO assistant and 2 support staff to provide services like ANC, Immunization, OPD and outreach services.

v. Service Delivery

State is in the process of conversion of UPHCs to e-UPHCs with revised OPD timings of 8am to 12 noon and 4 pm to 8 pm. There was a lack of clarity observed with regards to range of services that would be provided by the e-UPHCs at the field and district level. At present the expansion of services at the UPCHs is limited to launch of e- services like teleconsultation with specialist, generation of electronic patient record, linkage of drug supply with e - Aushadi and CORE dashboard based monitoring, additional lab tests and integrating RNTCP and NLEP services. Thus leaving out a range of services as per guidelines.

vi. Outreach Services

As the decision of State to run U-PHCs on PPP mode, there is lack of clarity among front line workers (ASHAs/ANMs) about their working arrangements and the outreach sessions to be conducted and their linkages with ASHAs.

vii. Community Processes

The ASHA programme has been in place since 2007 in urban areas. Approximately 94 percent ASHAs are currently in place as against the target, most of whom have received training up to round 2 of Module 6&7. ASHAs are functional as a facilitator and have good rapport in the community. Formation of MAS has been done in most of the urban areas with help of MEPMA or local NGOs managing the UPHCs.MAS bank accounts are yet to be opened.

viii. Quality

Urban PHCs are being upgraded under the CM UPHC Initiative and Quality Standards will be put in place.

ix. PPP

After the recent decision, State has decided to run UPHCs in PPP mode with Apollo.

x. Finance

Overall expenditure under NUHM is low. The funds for NUHM in the state till now only cover the budget for salary, contingency, rent and electricity for UPHCs.

2. Arunachal Pradesh

i. Planning & Mapping

Planning and mapping has been done in both the towns. There are 180 slums (notified and un-notified) in the state of which 139 are in the State capital.

ii. Institutional Arrangement & Program Management

State Program Management has been set up. At the State level, there is a Nodal Officer, one Urban Health Consultant, one Urban Health Accountant and one Data Entry Operator.

iii. Infrastructure

There are 3 UPHCs- Karsingsa and Itafort (Itangar Capital complex) and Pasighat. One UPHC is under construction at Rakap Colony in Naharlagun (Itanagar Capital complex area).

iv. Human Resource

All human resource approved at the two UPHCs (Karsinga and Pasighat) is in place. Huge HR of 18 staff is catering to an OPD of monthly average 4-5 patients/ day.

v. Service Delivery

In UPHC (Banaskata), Pasighat, both the staff and beneficiaries were unaware of MAS and Urban ASHAs. Incomplete pharmacy recordsandimproperlymaintained ANC recrds were observed in the visited facilities.

vi. Outreach services

Outreach sessions are being held in the slum areas but interaction with beneficiaries indicated that sessions are irregular. ANMs are being designated clinical mentors in their respective jurisdiction for handholding support of ASHAs.

vii. Community Processes

Training has been imparted to Urban ASHAs and MAS. So far 92 MAS and 42 Urban ASHAs have been trained in Module 6 & 7.

viii. Quality

Equipment maintenance was observed to be poor as the haemoglobinometre was broken in one of the facilities visited. Underutilization of human resource is an area of concern. State is in the process of purchasing of medicines and consumables for the existing & up graded UPHC.

ix. Finance

Release of fund is a main area of concern which is hampering daily routine work under NUHM. Loan from NRHM is being taken for the salary component of NUHM staffs. Some activities of 2015-16 are yet to be taken up for want of funds viz. up gradation of Itafort Dispensary (Rs.15.00 L) and purchase of medicines & consumables for Itafort UPHC, Itanagar and Pasighat.

3. Bihar

i. Planning & Mapping

The State has initiated the process of listing and mapping of notified and un-notified urban poor settlement in 15 cities having more than 50,000 population. The vulnerability mapping exercise is yet to be initiated.

ii. Institutional Arrangement & Program Management

Executive Director, State Health Society leads the process of NUHM program implementation with support from State Program Management Unit. Various program functionaries under the NUHM program have been recruited (State – 3, Cities – 3, and Districts – 60) recently through a transparent recruitment process. State is yet to provide training and orientation to the program staff on basic programme issues.

iii. Infrastructure

Infrastructure is deficient in the urban areas. Though the State has taken measures for the improvement in this regard yet out of the approved 81 UPHCs, 73 are functional. 60 UPHCs are in rented private buildings which are close to the slum population and rest are being run in government buildings.

iv. Human Resource

146 part time and full time MOs are in place. Recruitment processes for 243 staff nurse,

81 pharmacist, 405 ANMs are in process. Recruitment of staff under NUHM, both program and clinical has been difficult owing to low salaries, reluctance to work during evening shifts, unavailability of trained personnel in smaller towns, and slow recruitment process at the state level. Absence of staff at key positions is hampering implementation.

v. Service Delivery

There are 73 functional UPHCs in the State. UPHC provides OPD, ANC, immunization, and other counselling related services. Average OPD per day is 30-40 patients. The drug distribution system and basic diagnostic facilities are functional in UPHCs.

vi. Outreach

Both UHNDs and Special Outreach Health Camps are being conducted in urban areas. Monthly UHNDs are planned in each UPHC with ANC and Immunization services. The due-list is prepared by AWW and ASHAs.

vii. Community processes

Significant progress in the Community processes under the NUHM has been made. Out of the approved 391 ASHA, 332 ASHA have been selected. The State has not yet constituted Mahila Arogya Samitis (MAS) and is coordinating with National Urban Livelihood Mission in this regard.

viii. Quality

Induction of Urban Health nodal officer in state & district level QA committee has not been initiated

ix. Finance

Low utilization of NUHM funds with only 7%expenditure (upto 2nd quarter) has been reported.

4. Chandigarh

i. Planning & Mapping

Mapping of the slums was done by the Department of Urban Town Planning, Chandigarh in 2006 has been updated as per the survey records of ANMs. Spatial GIS mapping has also been done. All the health facilities have been mapped and reporting on HMIS done (100% facility-wise reporting).

ii. Institutional Arrangement & Program Management

NUHM is being implemented by the Department of Health, and the Municipal Commissioner has been nominated as a member of the Governing Body. The UT has initiated intersectoral convergence e.g. Alternative Medical Units" (AMU) which was launched in the year 2012 in lieu of Mobile Medical Units. The implementing partners were Departments of Health and Rural Development (space, infrastructure, furniture and maintenance of these centers) and NHM (management of AMU and HR).

iii. Infrastructure

Three Civil Dispensaries have been upgraded to UPHCs. One has been upgraded to the level of UCHC. 2 UPHCs are approved for renovation and both are functional. RKS are functional for all the UPHCs and UCHCs except one, with provision of untied grants.

iv. Human Resource

A total of 317 posts are sanctioned under NUHM, out of which 292 posts are filled up. Recruitment is done through walk-in-interview/ written tests.

v. Service Delivery

RCH, NCDs & Communicable diseases related services are provided at all the UPHCs. In all the UPHCs and UCHCs free drugs are provided to the patients (by the Health Department) but the diagnostics are chargeable.

vi. Outreach

The outreach activities are conducted by ANMs and ASHA workers for immunization, Family Planning and ANC/PNC only. The ANMs conduct outreach only for left out cases who do not come for immunization to the facility and record maintainenace needs strengthening.UHND is organised on every ninth of the month in UPHCs/UCHCs. Chandigarh Health Department organised eight multispecialty health cum screening camps in various health facilities in collaboration with PGIMER, MAX Hospital, GMCH-

32, State Bank of Patiala, UCO Bank, Chandigarh Transport Undertaking, and HelpAge India during 2016-17.

vii. Community processes

While ASHAs have been identified in urban slums, the UT is finding it difficult to identify members for Mahila Arogya Samitis. They are also exploring the possibilities of formation of Mother Health Groups.

viii. Quality

The UT has not designated a Nodal officer for NUHM in SQAC as necessary approvals are pending.

ix. PPPs

The UT has undertaken the following PPPs for urban health:

- MRI & CT Scan Centre - The Govt. Multi-speciality Hospital, Sector 16 and M/s SSS Diagnostic & Research Centre are running an MRI & CT Scan centre under PPP mode which is a 24 x 7 facility. The MRI charges are Rs.2700 per day. Around 25-30 cases are handled by the centre per day. 10% of the cases are done free of cost which are recommended by the hospital authorities.

- "eHealth Centre" has been conceptualized in collaboration with the Hewlett Packard Enterprise, PGIMER and Department of Health, Chandigarh. It is in the form of metallic containers to be placed in existing civil dispensary. The patient is seen by the doctor and then prescribed medication or lab test for which there is a provision in the e-HC itself. For consultation with a specialist, there is provision of tele-medicine wherein specialists sitting in the studio at PGIMER can be approached. Clinical diagnosis will be made followed by prescription or referral depending upon the case. Pharmacy is also available in the next cabin. This Centre will be made operational shortly.

- Lab Facility - NGO Bhartiya Vikas Parishad, has started a project in September 2016 where lab facility is extended to the general public in PPP mode in the EWS Dhanas. The cases which are recommended by the MO are done free of cost. It is a collection Centre and all routine investigations are done in this Centre.

5. Delhi

i. Planning & Mapping

The GIS based mapping for urban health institutions, slum area and vulnerable population has been completed. The identification of slum has been completed and mapping is in process for all the visited UPHC/UCHC catchment area.

ii. Institutional Arrangement &Program Management

The SPMU and 11 DPMU staff are in position but the 3 City Programme Management Unit (CPMU) have not been established nor the CPMU staff have been recruited.

iii. Infrastructure

All the facilities were located at distance of 0.5 to 2 km from the nearest slum. It was observed that in all the visited health facilities power back up was available except for 3 seed UPHCs in Shahadra district. Although the labour rooms were functional in the Maternity Homes, but require strengthening and should follow the norms laid down in MNH Toolkit, GoI guidelines. RKS not formed in all UPHCs & in 50% Maternity Homes (Though functional before FY 2014 but not after 2014 due to change of State Government) in both districts.

iv. Human Resource

553 (68%) human resource is in position out of 813 HR approved under NUHM. HR strengthening for all cadres is required in both the districts.

v. Service Delivery

Basic primary health care services provided was RCH oriented only, focus needs to be made to integrate with the disease control programme activities (i.e NVBDCP, NCD, RNTCP etc) leading to comprehensive primary care. Good uptake of health services observed in Aam Admi Mohalla Clinics.

vi. Outreach Services

Urban Health Nutrition Days were observed in Anganwadi centers located in urban areas every Wednesday and Friday. Though an ongoing activity, UHNDs were not conducted from April to September,2016 due to pending approvals.

vii. Community Processes:

4936 ASHA were in position out of 5567. About 92 percent were trained upto Module 5 and 89 percent upto Module 6&7. Mahila Arogya Samiti (MAS) formation is in process in whole state. The state ToT on MAS was conducted for the district ASHA Coordinators.

viii. Quality

Quality Assurance committees have been formed in both the districts. The process of assessment of health facilities in Shahadra district has not been started. A large number of lab equipments were non-functional at all levels of health facilities visited. Colour coded containers were available but not utilized as per new BMW rules & regulation.

ix. Finance

During the Financial Year 2016-17 total utilization of 20 % has been reported under NUHM against the total funds available. Untied fund neither disseminated nor utilized since FY 2013-14 in whole state.

6. Gujarat

i. Planning and Mapping

Mapping of vulnerable areas, slums and facilities undertaken in most cities is complete.

ii. Institutional Arrangement & Program Management

The State and District Health Mission have expanded to include the Urban Development Directorate officials and elected representatives.

iii. Infrastructure

Excellent infrastructure particularly in the facilities under the municipal corporation Gandhinagar and in Navsari. Most RKS registered under registered under Charity commissioner and untied fund transferred to the RKS accounts. Expenditure being made for facility improvement from the RKS funds. Location of the facility (Navsari) is very close to the slums making highly accessible for the community.

iv. Human Resource

Most recruitment complete. Capacity building activities in immunization, TB, malaria, IDSP, HMIS provided to the paramedical staff.

v. Service Delivery

The services imparted in the UPHCs include OPDs, ANC, NCDs, lab services and disease control programmes like malaria, TB and IDSP reporting. The timing of the facility is from 10am to 5pm with specialist (gynaecologist and paediatrician) coming on specific dates with a daily average OPD of 50 per day.

vi. Outreach Services

Micro planning for outreach services UHND (Mamta Divas) being undertaken. The location is the AWC and services include immunisation, ANC tetanus, blood sugar test and providing incentive in kind to mothers for each ANC visit undertaken. Referral for complicated and difficult cases also undertaken.

vii. Community Process

ASHA recruited in all places and most MAS constituted. Induction training completed, currently 6&7 module ongoing. MAS training scheduled through the NGO through a TOT model. MAS accounts opened and 50% funds transferred to the account. Expenditure made from the accounts for monthly meetings and other small activities and meeting records being maintained.

viii. Quality

SQAC and DQAC formed and the nodal officer of NUHM inducted into the committees.Assessment of facilities yet to start except in Ahmedabad.

ix. Financial issues

The overall expenditure of NUHM in the State is 76% for FY2016-

17 is 37% Financial transaction is through PFMS and registration of urban facilities under PFMS done. The ASHAs being provided incentives through DBT.

x. PPP

The already approved thalassemia project being implemented as an innovation under the municipal corporation Ahmedabad

7. Himachal Pradesh

i. Planning and Mapping

NUHM in HP covers 3 cities (Shimla, Dharamshala and Solan). Although vulnerability mapping has not been conducted, 12 high risk areas have been identified in Shimla to cater vulnerable (Migratory and Stationary) population of the district. Details regarding distinction between notified and un-notified slums were not available with the state.

ii. Infrastructure

At present State has 10 UPHC and 1 Lab (Run by Municipal Corporation) in Shimla, out of which 8 UPHCs were sanctioned for renovation/up-gradation from 2013-14 to 2015-16. Till date only three UPHCs up-gradation work has been completed.

iii. Service Delivery

Good patient load (60-80 daily OPD) was observed at the UPHC visited, with adequate staff and infrastructure. UPHCs have morning as well as evening OPD timings. X-Ray machine was unutilized due to non-availability of an X-Ray technician.

8. Jharkhand

i. Planning & Mapping

Detailed household survey, planning, mapping and vulnerable assessment have not yet been done in state. In Godda, there was no identified urban area. In Garwha the town area with 4 slums settled along the embankments and near the railway station is catered by an Urban PHC established recently

ii. Service Delivery

The UPHC provides general OPD and Lab services. Interaction with the slum population, it was concluded that they are aware of the UPHC and were accessing services but the only concern was the timings of the UPHC as the timings were from 10 am to 3pm and only those staying near the facility were able to access UPHC services during these timings.

iii. Community Processes

The MAS is selected through a consultative process and in the current financial year had 3 meetings (Garwha) where they discussed largely the coverage of slum population by the newly established UPHC. They however, find a problem with the vulnerability mapping since they stay all mixed up among the 'non-vulnerables'

9. Jammu & Kashmir

i. Planning & Mapping

The State has undertaken facility and slum mapping for all 7 cities/ towns. However Vulnerability mapping and GIS mapping is yet to be initiated.

ii. Institutional Arrangement & Program Management

The linkage of the Health department with the ULBs is weak. No convergence with ULBs in the 7 NUHM approved cities.

iii. Infrastructure

The pace of construction of health facilities is slow hence most UPHCs are operational in rented buildings. In some cases, the poor structure of the rented buildings raises safety issues for patients. RKS in the UPHCs have been formed recently but are presently non-functional.

iv. Human Resource

All Sanctioned positions at SPMU level have been filled, however 40 % of the DPMU levels position are vacant. 90% medical and paramedical level staff has been recruited and 47% have been trained. The PMU staff at District level and service delivery staff had mediocre knowledge about NUHM and other national health programmes.

v. Service Delivery

The basic facilities like OPD, pharmacy available at all the

facilities visited, however the OPD load is low at 20-30 patients per day. The UPHCs are non-delivery points with day time OPDs and laboratory facilities presently not available at some of the facilities though HR recruited for the lab. Medical officer and pharmacists were unaware about EDL. Though ANC and immunization facilities are available at the centre, the records are not properly maintained.

vi. Outreach

Outreach activities (UHNDs) have been started though in most places yet to be started.

vii. Community Processes

ASHA recruitment completed for NUHM. 53 ASHAs out of total 63 ASHAs trained so far. MAS are yet to be established across the State, however in Anantnag all the 22 MAS have been constituted with bank accounts. Training and capacity building activities yet to be carried out for MAS members.

viii. Quality

There is weak compliance of BMW management and infection control practices. No protocols for bin usage of bio-waste management being followed. Also no SOPs and STG available at all the facilities visited.

ix. Finance

Various accounting registers not maintained and Huge unspent balance at State and District level is recorded.

10. Kerala

i. Planning & Mapping:

Mapping and listing of slums (notified and non-notified) and health facilities, Spatial GIS mapping, vulnerability mapping and preparation of city health plans have not been undertaken in the entire state. The existing slum lists include only notified slums and these lists have been obtained from the urban local bodies; with last updating a few years back (2011 in case of Thodapuzha municipality).

ii. Institutional Arrangement &Programme Management

Urban Health Cell at State level and District Urban Health Cell has been established in all the 14 districts. Each District Urban Health Cell is manned by an Urban Health Coordinator and a DEO cum accountant. ULBs are proactively participating in implementation of NUHM through provision of necessary infrastructure (making space/ buildings available for UPHCs) and funds for paying the rentals.

iii. Infrastructure

All 83 UPHCs sanctioned under NUHM have been operationalized for strengthening the primary health care infrastructure in urban areas of the state. RKS or the Hospital Management Committees (HMCs) have not been constituted till date for the want of a GO from the state government.

iv. Human Resource

Most of the sanctioned programme management staff and clinical staff have been recruited. Specialist doctors are being engaged in the state instead of the part time MOs on designated days (UPHC Thodapuzha conducts ENT clinic thrice a week). However, attrition of medical officers is reported to be very high under NUHM

v. Service Delivery:

UPHCs provide out-patient services on all days except Sundays from 9 am to 5 pm in District Idukki and 2 pm- 8 pm in District Kollam. Average daily OPD of UPHCs ranges between 50-100 patients. UPHCs provide general OPD, routine immunization, disease surveillance, family welfare, outreach, dispensing services and additionally conduct screening and treatment of common NCDs like hypertension and diabetes. However UPHC Karunagapally in Kollam provided only OPD services and no other services.

vi. Outreach Services

Till Sept 2016, a total of 1551 UHNDs and 23 special outreach sessions have been conducted in urban areas as per the state HMIS data. However, special outreach sessions targeting the vulnerable groups/population are not being conducted in district Idukki.

vii. Community Processes

The state has a total of 1927 ASHAs working in urban areas.

However, ASHAs have not been placed in line with the GoI norm of one ASHA per 1000-2500 slum population and each ASHA is responsible for community engagement in an entire ward which may include both slum and non-slum population. MAS have not been constituted. State is planning to co-opt the existing Kudumbashree groups as MAS but no formal guidance/ communication from the state was issued till date.

viii. Quality

District Idukki has a District Quality Assurance Committee (DQAC) headed by the district collector and it meets on a quarterly basis to discuss issues related to quality assurance. However, the District Urban Health Coordinator was inducted in this committee only 2-3 months back. A facility level QAC has also been constituted at UPHC Thodapuzha under the leadership of the MO Incharge of the UPHC.

ix. Finance

Utilization of funds received under NUHM in state is 65% up to Sep 2016-17 with civil works, training, and procurements being areas of low utilization.

11. Maharashtra

i. Planning and Mapping:

All UPHCs in Nashik, Malegaon Nagpur Corporation have conducted basic mapping of their catchment area, as matter of routine practice. Facilities visited had displayed maps of the UPHC catchment area and location of slums. GIS mapping has not been conducted by the State and Corporations. Comprehensive city health planning was not observed in Nagpur or Nashik.

ii. Institutional Arrangements & Program Management

Additional MD for NUHM has not been deputed. All other State positions are filled. 29 CPMUs have been sanctioned and established at Municipal Corporations (4 for Mumbai and 25 for other corporations). There is a disconnect between the urban health and State health Mission so far as reporting and implementation of health programs are concerned especially in Nashik. Involvement of ULBs in NUHM implementation is good in Nagpur.

iii. Infrastructure

Most of the UPHCs are in rented buildings in both the Districts visited..

iv. Human Resources

Almost half of the vacancies of technical and managerial cadre are vacant. Clinical positions in the State are largely vacant.

v. Service delivery

Services provided at Nashik and Nagpur UPHCs include mainly general OPD, immunization and ANC and drug dispensation, and services through RNTCP, NVBDCP and NLEP. Many of the UPHCs in Nashik and Malegaon have indoor facilities and are delivery points.

vi. Outreach Services

Outreach camps are conducted for immunization and ANC, although not referred to as Urban Health Nutrition Days. Special Outreach camps are conducted quarterly by calling specialists such as gynaecologists, paediatricians etc

vii. Community Processes

Out of 522 urban ASHAs, 443 ASHAs have been recently recruited, but are not functional yet. Mahila Arogya Samitis are yet to be formed. The formation of MAS has been outsourced to NGO Sneha, which is yet to start work.

viii. Quality Assurance

In Nagpur5 UPHCs have been selected for Kayakalp in the Corporation. However, in Nashik no activity on QA has been undertaken in both the Corporations. In both the cities, otherwise, the implementation of Quality Assurance protocols needs strengthening.

ix. PPP

State has involved NGO SNEHA to support State in the formation of MAS which is yet to start work in Nagpur or Nashik.

x. Finance

So far there is an expenditure of only 19% from the total approved funds for 2016-17 by the Nagpur Corporation. However, in Nashik it is 2.04 Crores out of 5.63 Crores approved in RoP. Only 14/22 RKS are functional in Nagpur Corporation and 12 are in Nashik Corporation area.

12. Madhya Pradesh

i. Planning & Mapping

The state has initiated the process of GIS mapping in 2013-14. State has conducted a baseline survey of health indicators in 28 cities. Information collected on the health status and utilization of health care facilities by the urban population living in both Slum and Non-Slum HHs of 28 cities.

ii. Institutional Arrangement & Programme Management

Dedicated SPMU in place. Only 11 recruitments have been done against 47 sanctioned positions of APM.

iii. Infrastructure

Out of 5 sanctioned UCHCs, construction is under process in 3 & not initiated in 2 cases.

iv. Human Resource

There is 31% of shortage of MOs, 87% shortage of Pharmacist & 75 % shortage of LTs. At present the staff of SH Dept. is deputed to UPHCs, 97 MOs, 137 SN, 129 ANMs & 34 LTs are in place & functional.

v. Service Delivery

The MOs are dispensing medicines and performing lab test and the helper of Civil Dispensary is performing the duties of pharmacist and clinical staff as observed in most of the UPHCs visited in Ratlam & Bhopal. The Basic equipments are not available and non useful equipments have been placed in UPHCs. Costly testing kits for dengue and drugs with near expiry were seen at facilities in Bhopal. The Rogi Kalyan Samitis not constituted in all UPHCs due to which the untied fund is underutilized.

vi. Outreach

Area allocation is not well defined for ANMs & ASHAs as a result there is unequal distribution and many areas are left out in urban areas. ANM and ASHA cannot distinguish betweenUHND and Special camp.

vii. Community processes

So far, 4100 Urban ASHAs has been selected & 3455 MAS constituted in the state. Capacity Building of Mahila Arogya Samities and ASHA is required as the knowledge about NUHM is not updated. The untied fund for MAS has been released to only 30% samities and the members are unaware about the activities for which funds can be utilized..

viii. Finance

Only 22.96% of the funds approved under NUHM has been utilized.

13. Nagaland

i. Planning & Mapping

Vulnerability mapping has not been started. State is using GIS mapping under vector borne disease control programme, but will switch to own vulnerability mapping using GIS later-on. State is planning to do full disease profiling in identified urban areas through house-to-house survey.

ii. Institutional Arrangements and Program Management

The state has identified 5 urban areas under NUHM: Kohima, Dimapur-I, Dimapur-II, Mokokchung and Tuensang. State Programme Unit (SPU) led by NUHM Nodal Officer (Deputy Director Rank) with a consultant, accountant and office assistant works under State Health Society and coordinate NUHM at the state level. At district level, District Health Society under the chairmanship of District Collector is the coordinating agency. Usually, review meetings are conducted on quarterly basis at state and district level and only one state review meeting had been conducted.

iii. Infrastructure

Physical infrastructure for UPHC is near completion in Kohima

& Dimapur-I. At other places, sites have been identified but construction work needs to be started.

iv. Human Resources

Para medical positions are vacant in Tuensang, as the selected candidates declined the recruitment offer.

v. Service Delivery

All maternal and child health services and services related to other vertical national health programmes have been provided through UPHCs. Based on the information provided by the SPMU, performance of medical camps and UHND sessions is found better in Kohima and Dimapur-I as compared to other UPHCs.

vi. Community Processes & Outreach

79 out of 98 Mahila Aarogya Samitis (MAS) have been formed. Bank accounts of MAS need to be opened. In Tuensang district, all 15 MAS have been formed but no account has been opened till now. Microplans have been developed for conducting medical camps twice in month by each UPHC and UHNDs every week for each ANM.

vii. Finance

The funds for the financial year 2015-16 were received in Sep'16. Finances for financial year 2016-17 have been approved by GoI but have not been received.

14. Tamil Nadu

i. Planning & Mapping

Separate planning for NUHM for the Chennai Corporation and the rest of Tamil Nadu is being done. UPHC in Namakkal district is not established nearby any slum.

ii. Infrastructure

The pace of execution of civil works is better in case of rest of Tamil Nadu in comparison to the Chennai Corporation. Planning of the facility layout of UPHCs was also inappropriate e.g casualty in corner, male ward in front of labour room in Namakkal district.

iii. Human Resource

The State has staff in place in almost all the facilities visited. The State is appointing doctors through the Medical Recruitment Board to the regular cadre. The salary of the staff approved under NUHM is being deposited in the Treasury Account and then being further disbursed to staff as per state government norms.

iv. Service Delivery

The OPD timing of the four visited UPHC is from 9 Am to 5 PM, which may not be suitable for the vulnerable population of that area. The service delivery in the UHC located in Tirunelveli comprised of all MCH services including Family Planning and NCD screening. However, in case of UPHCs in Namakkal no services were provided except for immunization.

v. Patient Welfare Societies (PWS) are constituted in all UPHCs. The utilization of PWS funds was good and the funds released for the current financial year were utilized in nearly all the facilities visited. However, it was observed that the expenditure was incurred in the big items such as ECG machine, renovation works etc which are not as per the mandate of the PWS.

vi. Outreach

UPHCs conduct outreach services as per the planned schedule and the guidelines issued from the State. Services at special outreach camps are less comprehensive as hiring of the specialist is not been done as per the mandate. It is observed that the expenses for the camps were sometimes being incurred by MO-IC from their own pocket in-spite of sufficient balances in the bank account, but later reimbursed. The funds for UHNDs were released only in August, 2016 and the activity has not been implemented at UPHCs.

vii. Community processes

The formation of Mahila Arogya Samitis (MAS) is under process for the UPHCs functional under the Chennai Corporation, whereas the two visited district do not have MAS.

viii. Finance

The overall utilization under NUHM is 76.24% upto the second quarter of the F.Y. 2016-17 against the available funds. The areas of low utilization include Training and Orientation, Community Processes, IEC/BCC, Innovations and PPP activities which should be focused. At the State level, funds are released activity wise to the DHS which is transferred to the UPHCs. Whereas, in case of Chennai Corporation, funds are transferred to the City Health Society from the State which was then transferred to Treasury Account of the Municipal Corporation for further disbursement to the UPHCs/ UCHCs. However, Chennai Corporation is not transferring any funds for the activities to the UPHCs except outreach camps and the Patient Welfare Societies are not disbursed to the UPHCs under the Corporation. The other activities such as IEC/ BCC, office expenses which are being carried on by the UPHCs from expenses of Municipal Corporation were not been booked under NUHM resulting in low expenditure.

15. Tripura

i. Planning and Mapping:

The state had carried out mapping of health facilities prior to the launch of NUHM to assess the availability of infrastructure for the programme. Vulnerability mapping is currently underway.

ii. Institutional Arrangements and Program Management

The Member Secretary of State Health Society is the designated State Nodal Officer of NUHM and under his direction one SPMU official looks after the programme and concerned Manager of SPMU of NRHM is working for this programme. At the district level, District Health Society is the implementing agency and DPMU functions as secretariat for NUHM implementation.

iii. Infrastructure

The Infrastructure Development Funds were handed over to the Municipal Corporation, who has undertaken the infrastructure upgradation work. Urban PHCs will be set up across 7 locations under NUHM. Of these 5 UPHCs are located under AMC areas of West District and 1 UPHC each in Udaipur and Dharmanagar Municipal Council areas of Gomati and North Tripura districts.

iv. Human Resources:

The state is deficient in manpower – especially Medical Officers. The salary of Rs. 30,000 offered for the MO for Urban in UPHC is insufficient. Currently, regular MO's from other health facilities in Agartala have been deputed to these UPHCs to manage the facilities and operate the services.

v. Service Delivery

Currently OPD services are being provided in the UPHCs. Immunization and family planning services (spacing) are currently provided. However, services for other disease control programmes are yet to start.

vi. Outreach services

For providing outreach in the slums of the areas, UHND and Outreach camp is being organized in the 1773 Anaganwadi centres in the urban slum areas with active involvement of MAS, ANMs and ASHAs.

vii. Community Processes

For the urban program 80 Mahila Arogya Samitis (MAS) under Agartala Municipal Corporation (AMC) have been selected and trained as per GOI module. The MAS groups have received their seed money in their respective bank accounts.

viii. PPP

Outreach camps in slum area are organized in PPP mode with Ramakrishna Mission as per advance micro plan. As an innovation State has initiated ASHA Varosa Divas to recognize the services of ASHA.

16. Uttar Pradesh

i. Planning & Mapping

District Firozabad is having 3 Cities (Firozabad, Shikohabad and Tundla) and total 12 UPHCs. District Gonda is having only 1 city Gonda and having 2 urban PHCs, all of which are functional.

ii. Institutional Arrangement & Program Management

Convergence mechanisms to bring together stakeholders such as MoHFW, WCD, water and Sanitation is in place through DHS.

iii. Infrastructure

Gap analysis for infrastructure and equipment has been done at all UPHCs and required equipment has been indented.

iv. Human Resource

All posts in UPHCs of Firozabad are filled and ASHAs have been selected.

v. In Gonda, out of the two UPHCs, one of the facilities (Bariyar Purwa) is headed by a Medical Officer; post is vacant in the Civil Line facility. Both the UPHCs do not have a part time Medical Officer. Posts of 3 ANMs are vacant in Civil Lines UPHC while one post is vacant in the Bariyar Purwa facility. ASHAs are yet to be selected in both the catchment areas.

vi. Service Delivery

RCH services (OPD, ANC/PNC, Immunization, FP and Referrals), treatment for Communicable diseases, and investigations for Malaria, Blood Sugar, HIV are available in the UPHCs. Referrals are done for RNTCP, Mental Health and Leprosy. Local Purchase is not being done. Delivery services are not available in Gonda UPHCs. Essential Drugs and equipment are available at facilities. Procurement of medicines & consumables for UPHCs is done through CMO store on indent.

vii. Outreach

In Gonda, Calendars are prepared and UHNDs are conducted at the UPHCs. Outreach activities are conducted in UPHCs under the MO with support of Staff Nurse, Pharmacists, Lab Technician, ANM and other staff. In Firozabad, it is observed that UHND is conducted at clinic of an unqualified private practitioner. There is no information on display about day, timing or services provided in the UHND. Distribution of medicine and immunization is being done at UHND but no counseling is being provided on health or nutrition.

viii. Community Processes

Mahila Aarogya Samitis (MAS) and Rogi Kalyan Samitis (RKS) are not yet formed under the UPHCs. In Gonda district, Urban ASHAsare yet to be selected. InFirozabad ASHAs have been selected.

ix. Quality

DQAC committees have been formed and meetings are conducted. Patient feedback system is in place in UPHCs- Complaint box has been put up for suggestions/complaints which are reviewed by Nodal Officer, and CMO along with Urban Programme Coordinator.

x. PPPs

District Male Hospital, Firozabad has just entered an MOU with M/S Chandan Healthcare Ltd., Lucknow for providing high end laboratory tests free of cost to patients. Service provider will charge at a 5.10 % discount on CGHS rates to the government.

उपभोक्ताओं / मरीजों की अधिकार सूची

- मरीजों को उच्चकोटी की चिकित्सा सेवा उपलब्ध करवाई जाएगी ऐसे मरीजों को जिसकी बिमारी के इलाज के लिए यहां व्यवस्था न हो और दूसरे अस्पताल में जहां इसकी व्यवस्था हो को समय पर भेजा जायेगा।
- मरीजों को सौहार्दपूर्ण तरीके से देखा जाएगा और उनका सम्मान, ईमानदारी तथा निष्कपट भावना से इलाज किया जाएगा।
- मरीज के आत्म गौरव का सम्मान किया जाएगा उसकी बिमारी को गुप्त रखा जाएगा और उसकी सहमति के बिना किसी दूसरे आदमी को उसकी बिमारी के बारे में नहीं बताया जाएगा।
- मरीज को अपनी बीमारी के बारे में इस्तेमाल विधियों तथा इलाज और उसके होने वाले खतरों के बारे में पूर्ण जानकारी दी जायेगी।

बाह्य रोगी विभाग

- मरीजों को जल्दी से जल्दी देखा जाएगा।
- वरिष्ठ नागरिकों तथा विकलांग मरीजों को पहल पर देखा जाएगा।
- ज्यादा सिरियस मरीजों को जल्दी देखा जायेगा।
- मरीजों को साफ सुथरा तथा सौहार्दपूण वातावरण दिया जाएगा।

इन्तजार का समय

- पर्ची पर लगभग 10 मिनट और डॉक्टर तक पहुँचना लगभग 30 मिनट।

दवाईयाँ

- मरीज को दवाईयाँ जो कि सुरक्षित प्रभावशाली तथा अच्छी ही दी जाएगी।
- अस्पताल में उपलब्ध दवाइयों की सूची की जानकारी दी जाएगी।

अस्पताल में छूट्टी

- मरीजों को छुट्टी के बारे में कम से कम एक दिन पहले बता दिया जायेगा।
- छुट्टी के कार्ड पर मरीज को दवाईयां तथा अन्य सलाह दोबारा आने का दिन भी लिखा जायेगा या अगर आवश्यक हो तो रेफर लिखा जाएगा।

उपभोक्ताओं की कर्तव्य सूची

- मरीजों के बिस्तर पर बैठना मना है।
- किसी भी समय दो से अधिक रिश्तेदारों को मिलना मना है।
- अपने बिस्तर के आस-पास सफाई रखें।
- रिश्तेदारों का वार्ड में खाना-पीना मना है।
- बाथरूम में बर्तन धोना मना है।
- बाथरूम में रुई इत्यादि फ्लैस में मंत डालें। इसके लिए बाथरूम में कूड़ेदान का प्रयोग करें।
- वार्ड परिसर में मोबाईल टेलीफोन इस्तेमाल करना मना है।
- रिश्वत देना मना है। बिना रसीद के पैसे न दें। अगर कोई स्टाफ शगुन या अन्य काम के पैसे मांगता है तो खण्ड चिकित्सा अधिकारी को सूचना दें।

मैडिकल रिकार्ड

- मरीज के रिकार्ड को गुप्त तथा सुरक्षित रखा जाएगा।
- मरीज अपने रिकार्ड को 10 रु० भुगतान करके लिखित प्रार्थना के बाद कभी भी ले सकता है।
- अगर पुलिस केस न हो तो लाश को तुरन्त रिश्तेदारों के हवाले कर दिया जाएगा।
- अस्पताल में हुई जन्म व मौत का प्रमाण पत्र ग्राम पंचायत जंजैहली से 15 दिनों बाद प्राप्त किया जा सकेगा।
- गरीब परिवारों से सम्बन्धित मरीजों के अस्पताल में किये जाने वाले टैस्टों की सुविधा पूरी तरह मुफ्त है।
- सुझाव के लिए सुझाव पेटिका का इस्तेमाल करें या खण्ड चिकित्सा अधिकारी को कमरा न० 104 में सम्पर्क करें।

वार्ड

- मरीजों के दाखिले के लिए सम्बन्धित वार्ड की स्टाफ नर्स की पर्ची दिखानी होगी।
- बिस्तर अगर खाली हो तो मरीज को 5 मिनट में उपलब्ध करवा दिया जायेगा।
- मरीज को डॉक्टर 15 मिनट में देख लेगा।
- आवश्यकता पड़ने पर ज्यादा बार भी देखेगा।

TOR 11 | GOVERNANCE and Management

OBJECTIVES

- Review the functioning of State Health Mission, State Health Society- governing body and executive body, operations of district health societies, the district planning process and use of evidence (survey data/HMIS/MCTS/SS visit reports) for planning purposes at various levels.
- Review the integration between the Directorate of Health Services/Public Health and State/District Health Society/PMUs and link with educational institutions.
- Assess functioning and organization of State PMU (including for NUHM), integration of various programme management structures, mechanism for performance assessment of Staff, field visits and system of review of the program and supportive supervision mechanism.
- Review CEA and PCPNDT implementation.

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4) Review CEA and PCPNDT implementation.

National Overview

Good governance mechanisms provide strategic direction for policy development and its implementation; detect and correct undesirable trends & distortions, and also provide for creating an enabling environment in which health workers and

programme managers function effectively within a transparent and accountable framework. For instance, regular meetings of State Health Missions and District Health Missions are a requirement under the framework of erstwhile National Rural Health Mission as well as the now operational National Health Mission. However, analysis of data from previous years show that number of State Health Mission meetings have decreased from 54 (in the year 2006-07) to 34 in 2015-16. With better understanding of governance mechanisms, it is possible that State Health Missions are meeting at a relatively fewer frequency; however, given the challenges that previous TORs have reported it is desired that State Health Missions meet at a more regular frequency. The current CRM also reports that health mission meetings at State and district level is not happening regularly, except Gujarat, Delhi, Chandigarh, Kerala and Tamil Nadu. Rogi Kalyan Samitis, that have role in supporting health facility level governance, have not been formed at about 27% of the PHCs. However, at higher level health facilities these samitis have institutionalized to a large degree. All States and UTs have reported establishment of SPMUs, DPMUs or associated structure. However, the program management structure remains relatively weaker at block level. For instance, of 5,562 BPMUs that have been established in the country, 1878 (33%) function without a Block Program Manager. Such human resources constraints directly affect the planning and monitoring of services, as is also reported by the CRM teams from different States. Programme management structures are pillars of the mission and steps that weaken this system need to be addressed on priority. Coordination with urban local bodies remains a challenge. Health system strengthening initiatives like innovative proposals to improve health services outreach, death reviews (MDR/CDR); transparent system for appointment, transfer & posting with an HRMIS; and Centralised Procurement Management Information Systems are struggling to pick up.

Key Findings

1. Institutional mechanisms

The health mission meetings at State and district level are not happening regularly, except in Gujarat, Delhi, Chandigarh, Kerala and Tamil Nadu.This has been a weak-link since the societies at State and District implement the programmes supported by NHM without a policy direction and steering from the Health Mission. This affects planning and implementation of every programme in quantitative as well as in qualitative terms and does not create an enabling environment for developing innovative approaches and best practices to solve local health problems. The meetings of Health Missions are not perceived as a priority by any State.

2. Planning Process

Decentralized planning process is a core system strengthening instrument of NHM which is not robust in many States and has almost come to a standstill. Planning process is perceived as planning for NHM funding mostly whereas it was envisaged that the planning of health should be the reflection of community needs and experts input. In all States the district planning process is not seen as a dynamic process that requires institution memory and extensive partnership.

While States such as Gujarat, Himanchal Pradesh, Kerala, Tripura and Maharashtra have initiated planning from village level and resource envelops are constituted to aid realistic planning; others such as Andhra Pradesh, Arunachal Pradesh, Bihar, Jammu Kashmir, Jharkhand, Madhya Pradesh, Nagaland and Uttar Pradesh, have not prepared their SPIP as per DHAP sent by districts and they have not allocated budget as per the District Health Action Plan. Planning process is perceived in the States as budget preparation exercise rather than an empowerment tool for decentralised participatory planning to develop health plans to address local health needs and aspiration of people.

3. PMUs & Integration with Directorate, Convergence

Clearly defined organogram, functions and job descriptions of various Programme Management Units are in place in Madhya Pradesh and Maharashtra. All program management staff under NHM (including those under NCDs) are brought under SPMU in Arunachal Pradesh, Gujarat, Maharashtra. Rationalization of HR is attempted in Gujarat and Jharkhand. Except for a few States like Tamil Nadu & Maharashtra, integrated working of Directorate and NHM PMUs was lacking in all States. Capacity development initiatives by States for PMU staff were not seen in any of the States. Good performance assessment systems for PMU staff were observed in only a few States/UTs like Madhya Pradesh, Jharkhand and Chandigarh. Convergence with line departments like WCD, Education, Sanitation, Urban development was observed in States like Gujarat, Kerala, Maharashtra, Jharkhand and U.P and in these States the representatives of line departments were included in the State and District health missions and they have active involvement in the RBSK, Urban health, immunisation programmes. Strong presence of Local Self Government in supporting the facilities (by contribution of funds for infrastructure, drugs etc.) and close monitoring of functionality has added a positive dimension in health care delivery in the State of Kerala. In the remaining States, areas of convergence with other line departments are not clearly mapped out/explored and coordination with urban local bodies remains a challenge. Plan of action, framework for convergence has not been established.

4. Review and Supportive supervision

The overall review and supportive supervision mechanism as per GOI guidelines are weak across many States. However, state level supportive supervision team is proactive in the States of Gujarat, Himachal Pradesh, Bihar, Jharkhand, Maharashtra, and Tamil Nadu. Regularity in monthly

review at all levels is observed in Kerala, Maharashtra and Gujarat.

The frequency of visits made is low in comparison to that planned in almost all States except Bihar. Bihar has developed software for monitoring of the findings of supportive supervision and action taken report from the visited facilities. In Delhi, Kerala and Tamil Nadu corrective actions based on field visits were observed.

District Level Vigilance & Monitoring Committee (DLVMC) as per GoI guidelines has been successfully reconstituted in Gujarat, Bihar, Jharkhand, Kerala, Maharashtra and Tamil Nadu. In Kerala elected representative of Panchayti Raj and Urban local body are also doing review as per the powers given in Act and rules of the state.

5. Regulation

States that have implemented Clinical Establishments Act 2010 are getting temporary registrations and are planning to move to permanent registration once all standards are notified. Arunachal Pradesh, Bihar, Himachal Pradesh, Jharkhand and Chandigarh have notified State CEA rules, State councils and District authorities. Delhi, Andhra Pradesh, Maharashtra, Madhya Pradesh and Nagaland are following state specific Act(s) which regulates just the private clinical establishments. States are attempting to align these Acts with the key features of central CEA, 2010.

The level of implementation of PC-PNDT Act is abysmal. Lack of witnesses and insufficient evidence are cited as major reasons that result in cases falling through, thereby resulting in low conviction rates. The Act is inadequately used while drafting court complaints and the full force of the law is often not brought to bear in prosecution.

There is a strong need to work towards greater engagement with and empowerment of implementing authorities. The same can be achieved through intensified training and sensitization of implementation authorities with a focus on follow-up and impact assessment of training/sensitisation programmes. Strengthening case law documentation, legal processes and rigour through a set of actions involving medical professionals, civil society and community leaders can contribute significantly to a much more robust legal approach and ensure better implementation of PC-PNDT Act

Recommendations

1. Lack of proper integration between NHM and Directorates is hampering the implementation and progress various key national programs in the States. A proper frame work with action plans needs to be worked out for better integration and output.

2. States/UTs need to take up capacity building initiatives for PMU staff at state and district level on a regular basis.

3. The convergence with line departments, if taken up properly can lead to substantial gains for the community as a whole e.g. the convergence with Education department - The Schools can be used as an effective platform for generating demand and creating awareness for programmes such as WIFS.

4. Districts should prepare five years' prospective plan with the support as per Gaps identified in NQAS for facility based planning and Panchayati Raj Institutions and ULBs should be involved in community based planning to address social determinants of Health and sustainability of planning exercises.

5. Allotment of funds to the districts and blocks should be a flexi-pool under the broad head. However, once the activity is accomplished the

expenditure should be booked against the relevant FMR.

6. States must ensure involvement of other departments in preparing district action plans/district PIP since many activities under health are cross cutting and can be implemented by the better expertise of the concerned departments.

7. All ULBs and Panchayat representatives should also be oriented on the programme and policies of NHM so that they can also do informed supportive supervision of the health facilities.

8. The SHM and DHM members' participation helps in improving and accelerating the various initiatives under NHM. So adequate orientation and advocacy with the chairpersons the members need to be undertaken to realise the shared vision of NHM.

9. District Collector's orientation in NHM activities and various governance mechanisms must be undertaken by all States.

10. Raise the discourse through advocacy and campaigns, mobilize civil society as agents of change, and community-level watchdogs of malpractice to promote a culture of accountability.

11. State must organise orientation workshops for implementation of Clinical Establishments Act 2010.

12. Focus on Districts/Blocks/ Villages with low Child Sex Ratio to ascertain the causes, plan appropriate Behaviour Change Communication campaigns and effectively implement provisions of the PC & PNDT Act, 1994

State Findings

1. Andhra Pradesh

- The building of institutional structures post formation of the state of Telangana is still in progress.
- A draft on Clinical Establishment Bill has been developed by the state drawing features of the central Act.
- Various Committees required to be set up under PC-PNDT Act have been set up and provisions of the Act are being implemented. There are 19 ongoing court cases under the Act. Lack of evidence and out of court settlement has been the main reasons for dismissal of cases.

2. Arunachal Pradesh

- The State PMU is functional and active but there is minimal integration between the Directorate and the SPMU. Though some of the officers from the Directorate are working for NHM and are currently posted in SPMU, the Directorate is not consulted regularly for NHM activities.
- The State has initiated the implementation of CEA and registered 523 private nursing homes.
- No case has been registered under PC-PNDT Act yet. The State is yet to have a focused implementation plan on the PC-PNDT Act.

3. Bihar

- Convergence with other departments was found to be weak, especially at the field level.
- Appropriate representation of Urban Development Directorate, Urban Local Bodies, related officials and experts yet to find place in the SHM/SHS and DHM/DHS
- The statutory bodies/ committees under CEA - State Appropriate Authority, Advisory Committee, State Inspection and Monitoring Committee, Supervisory Board - have been constituted.
- The implementation of PC-PNDT Act is picking up. Indian Medical Association has created a committee which attempts to spread awareness about the Act among doctors who own clinics or use ultrasound machines.
- Most of the functionaries received their knowledge from workshops organized by the NGOs that are working to

sensitize the community on the Act. Inspection of clinics needs to be done on a regular basis.

4. Chandigarh

- NHM has very good performance appraisal system for the contractual staff. There is no blanket extension at the end of completion of tenure. The extension is granted on the basis of performance assessment of their work done in the allocated sphere of activity.
- There is need for rationalization of HR considering health system approach. The different National Health Programmes under NHM cannot be compartmentalized during implementation phase while considering deployment of staff. It should be possible for the supporting staff to render assistance to different National Health Programmes and therefore the need for rational deployment of HR.
- The CEA has been implemented in the UT. Professional awareness workshops and training for the clinics registered under CEA 2010 and training for IMA members have been conducted.
- Various Committees required to be set up under PC-PNDT Act have been set up and provisions of the Act are actively implemented and closely supervised by the District Family Welfare Officer.

5. Delhi

- The IDHS, District RKS and the RKS has members from all the line departments like social welfare, education, PWD, MCD, state government etc.
- All the programme management positions are under the NHM except NCD as no staff has been appointed/approved at the district level.
- Need more convergence with MCD, Dept of Social Welfare, Education, NGOs. The IDHS, District RKS and the RKS has membership from all the line departments like social welfare, education, PWD, MCD, state government etc. The Social welfare is supporting in organizing the UHNDs and providing nutrition to the children, pregnant & lactating women and adolescents. Education department collaborates for WIFS programme and NGOs for healthcare needs, immunization and service provision.
- There is lack of awareness in public regarding the penal provisions under the PC-PNDT Act. Currently there are 58 ongoing court cases under the act.
- Delhi has a state specific act for regulating private clinical establishments

6. Gujarat

- There is limited attention on capacity development initiatives by the State for programme management along with no system to assess staff performances
- Under PC-PNDT Act, all facilities have been registered. However, implementation is a challenge as it requires gender disaggregated data for all ages to determine the trends of sex ratio.
- Under NHM all programmes have been well integrated particularly all National Programmes, Immunisation, AYUSH services and RBSK activities. There is strong integration between the Directorate and the programme management units as well.
- Convergence has been observed with other line departments such as WCD, Education and Urban development. Representatives of these line departments were included in the State and District health missions and they have active involvement in the RBSK, Urban health, immunization and Mamta Diwas programs.
- The State has not yet been implemented central legislation (CEA 2010) and also does not have its own legislation on clinical establishment.

7. Himachal Pradesh

- Support for DPM and other Program Management Staff needs to be sought in PIP and approved BPM posts needs

to be filled for strengthening of program management unit as well strengthening of supervision and monitoring activities.

- PC-PNDT Act is being implemented through State Supervisory Board, State and District Appropriate authorities and Advisory committees duly notified by the government. Regular Inspections are carried out. Extensive IEC activities are also carried out.

- CEA Rules have been notified and the Act and Rules uploaded on the website. The State Council for Clinical Establishment and the District Registering Authority have been notified. DEO of all districts have been trained. Online registration started from October 2013 and to date 8978 applications and 6004 registrations done.

8. Jammu and Kashmir

- Lack of convergence between departments/agencies on common areas of work was observed. For instance, there is no convergence amongst the sub-centre, anganwadis, VHSNC to address the issue of menstrual hygiene or for reducing incidence of open defecation and promote usage of toilets etc.

- The State has not yet implemented the Clinical Establishments Act.

- The PC-PNDT Act is being implemented. However timely renewal of license was an issue.

9. Jharkhand

- A financial management guidebook is prepared by NHM, Jharkhand which brings clarity to the devolution of powers. Rationalizing HR positions under programme management units is under process and prime concern is to address salary disparity.

- The performance assessment of staff is done through self appraisal and review by superiors. There is a structured format and observations are submitted to MD(NHM) for approval.

- CEA has been implemented in the state. Appropriate authorities have been constituted and registration has been nearly completed, including that of private hospitals. The data of registered institutions (5035) is available online.

- PC-PNDT Act has been implemented in the state and in the last year two cases have been filed with no convictions as yet. There are 3 districts with low sex ratio – Palamu, Pakur and Dhumka which have been selected for 'Save the Girl Child Programme'.

10. Kerala

- Strong presence of Local Self Government in supporting the facilities (by contribution of funds for infrastructure, drugs etc.) and close monitoring of functionality has added a positive dimension in health care delivery of the State. This remains the major point of convergence of departments/ programmes which is a role model for other States.

- PCPNDT Act has been implemented in the State. Total 1732 clinics and around 35 IVF centres have been registered under the act. There is a PCPNDT committee at the district level which is meeting periodically.

- The state has drafted the Clinical Establishment Bill, drawing features from central Act, which is yet to be passed in the state assembly.

11. Madhya Pradesh

- No systemic and comprehensive orientation on various critical programme issues and check points for PMUs working at various levels.

- Performance monitoring, systemic appraisal and comprehensive assessment of staff in place.

- There is a need for better coordination between NHM/ SPMU and health Directorates and rationalization of staff is not yet attempted.

- The state has not enforced CEA, 2010 but M.P. Nursing Home Act 1973 is in force.

- PC-PNDT Act has been implemented in that state but all facilities have not yet been registered. There are 11 ongoing court cases under the act.

12. Maharashtra

- The SPMU is in close contact with all the programme divisions at the State level. Timely in-service trainings are carried out for the newly hired staff.
- Convergence with ICDS, Education and Sanitation departments, PRIs was observed. The review meetings with the CEO include a multi-department agenda and are closely followed up by the CEO in subsequent meetings. The Medical Colleges also attend the meeting with CEO especially in relation to the RBSK implementation. FOGSI is actively involved in PCPNDT meetings.
- State has developed an Act drawing lessons from CEA, 2010 which is awaiting enactment.
- PCPNDT Act is being implemented across the State. Regular inspection reports were seen. Online complaint portal in place. At the State level, 477 cases are pending, 50 doctors have been de-registered for 5 years and 9 permanently.

13. Nagaland

- SHM review meetings with districts are largely held viaVideo conferencing, which is a good model for States with difficult terrains.
- The state has notified Clinical Establishment Act. The State had the Healthcare Establishment Act and the same is being amended.
- The State needs to start implementing the PC-PNDT Act effectively including constitution of committees' a per the act, registration of USG machines and clinics, inspections etc. No case has been registered under PC-PNDT Act yet.
- DLVMC has been reconstituted in the current financial year only.

14. Tamil Nadu

- In the State very good integration between State Health Directorates and NHM was observed. System of program review at regular interval at State and district level is in place. The cadre structure in the state is facilitating smooth functioning.
- PC-PNDT Act has been implemented and authorities at various levels have been formed as per the Act. USG machines in facilities visited were found to have the license but mandatory declaration board under PC-PNDT Act was not displayed at the sites. 90 cases are being prosecuted till date.
- State is planning to enact CEA on the basis of central Act but the case filed by IMA against the move has been a set-back.

15. Tripura

- All Programme Management (PM) positions under NHM have not been brought under the SPMU/DPMU yet.
- Extent of delegation of financial powers requires a re-look since current guidelines do not aid facility in-charges in performing their duties optimally
- Clinical Establishments Act (central) has not been implemented in the state but state has own act in place.

16. Uttar Pradesh

- Programme management structures do not deliver as envisaged by programmes. Handholding by divisional level structures should continue to support the districts.
- Convergence with WCD at the field level observed.
- The state is in the process of adopting the CEA, 2010. CEA rules are passed in July 2016. State has also issued G.O for notification of State council and district authorities.
- IEC, field inspections, etc. for Implementation of PCPNDT Act is not very visible.

STATE POSITIVES AND CHALLENGES

ARUNACHAL PRADESH

REVIEW TEAM

East Siang	Upper Siang
Dr. S K Sikdar DC- I/C FP, MOHFW	Dr. Paul Francis, WHO
Ms. Mona Gupta, Health Lead, TSA, Deloitte	Dr. Meerambika Mahapataro, Associate Professor-NIHFW
Smt. Shanti Negi, US-FMG	Mr. Anil Gupta, Consultant, PHP, NHSRC
Mr. Rajesh Nallamothu, Consultant, QI, NHSRC	Sh. Sunil Kumar, US-MS
Dr. Vineeth Varanasi, Associate Advisor (ITSU-PHFI)	Ms. Karter Lombi, PHFI
Dr. Pralip Kr Narzary, Associate Prof.-IIPS	Dr. Sunil S Raj, Senior PH Specialist-NIPI-PHFI
Dr. Nitasha M Kaur, NHM	Mr. Arvind Kumar, IPE Global
Mr. Vishal Kataria, CH	
Dr. Pranjal Jyoti Baruah, Scintist-B, ICMR	

POSITIVES

- Majority of the people utilize public health facilities (81-87% for outpatient care, rest rely on informal providers) and 90% for inpatient care (71st NSSO) due to almost non-existent private sector throughout the State.
- The State has adequate number of health facilities. There are well distributed Sub Centers with sufficient human resources as per IPHS, almost reaching the WHO norm of 23 Health care providers per 10,000 population.
- The State has a lower Infant Mortality Rate (IMR) compared to the rest of the country (30 in 2014). Overall Arunachal Pradesh has better child health indicators compared to the national average and has already achieved the MDG-4 target of reduction of infant deaths.

DISTRICTS/INSTITUTIONS VISITED

Type of Facility	Facilities visited at East Siang	Facilities visited at Upper Siang
District Hospital	• District Hospital (General Hospital)- Pasighat • District TB Hospital- Pasighat	• District Hospital Yingkiong
CHC	• CHC- Mebo • CHC- Ruksin	• CHC Mariyang • CHC Jengging
PHC	• PHC Sille • PHC Bilat	• PHC Jeying
Sub Centre	• Sub centre- Ayeng. • Sub centreMottum • Mangnang • Mirem	• SC Karko • SC Simong
NUHM	• Urban PHC, Pasighat	
Others	• DMO office, Pasighat • Joint Director (Health Services) office, Pasighat.	• DC and DMO office, • DPMU office • Village community

CHALLENGES

- The Out of Pocket Expenditure (OOPE) in case of child birth in rural areas is higher than all India average (i.e. Rs. 2,092 in Arunachal compared to Rs. 1,572 all India average) and in the year 2011-12, 6.3% of the households reported catastrophic OOPE. Patients reported significant OOP expenditures (ranging from Rs.3000-5000) - both for drugs as well as diagnostics.
- Utilization of the facilities, ambulance, MMUs and productivity of HR is less than adequate and in some cases abysmally low. Most CHCs have a case load of 4-5 per MO, whereas in PHCs it is 1-2 cases per MO. Ambulances cater to 8-9 patients per month, whereas the MMUs operate only once a month.
- The State does not have a streamlined procurement system and has not yet notified free drugs and free diagnostics schemes.
- There is shortage of medicines and basic drugs like IFA, ORS, and Zinc was not available. ASHAs do not have the required drugs in their drug kits.
- Family Planning Service delivery is almost defunct at all levels with lack of motivation both at the district and sub district level.
- The technical knowledge of the staff and skill retention after training is below the expected levels. There is no competency based skill test for recruitment.
- Supervision and monitoring is non-existent.
- Fund movement from State to districts is too slow and is hampering the implementation of the programs. In FY 2015-16, the funds reached the districts in January 2016. ASHA and JSY incentives are delayed.

ANDHRA PRADESH

REVIEW TEAM

Krishna	Kadapa
Dr. Pradeep Saxena	Sh. Anupam Kumar Verma
Dr. Anuradha Medoju	Sh. A Muralidharan
Dr. Janardhan Rao	Dr. Dilip Singh
Dr. M. Jayaram	Dr. Garima Gupta
Dr. Mohd Samiuddin	Dr. R. Hari Kumar
Sh. Satyajit Sahoo	Dr. Pranay Verma
Dr. Deepak K.G.	Dr. Rajesh Kumar
Dr. Ala Narayana	
Sh. Kumar Vikrant	
Sh. GEORGE SEBASTIAN	

POSITIVES

- Use of information technology and institutionalization of the same in implementation of Health & Family Welfare activities.
- Free Diagnostics and Drugs schemes is operational in the State and PMSA is being effectively rolled out.
- Good linkages between Blood Banks and Blood Storage Units was observed. State has also introduced a Blood Bank Application to further increase voluntary donations which are now up to 80%.
- Special campaign "Domalpai Dandayatra" to create awareness in the community is being carried out. Every Friday is observed as 'Dry Day' for Vector control and every Saturday as 'Sanitation Day'. 'Mosquito Breeding Prevention Act' has also been approved by cabinet.
- Mahila Master Health Checkup for screening all 35+ women for common NCDs and cancers - Oral cancer, Breast Cancer and Cervical Cancer, Hypertension, Diabetes, Thyroid and other obstetric conditions – at SHC level is being carried out.
- Good convergence at SHC / PHC / Village level is observed under "Mana Bhavitha and Anna Amrutha Hastam".
- ASHAs are functional in the role of facilitator and are able to reach out to the marginalized families.
- Services under Programmatic Management of Drug Resistant TB, mandatory TB notification and CBNAAT services have been implemented effectively in the State. E-Smart, which is an IT tool for minimizing the diagnostic and treatment delay and tracking TB patients, is also being used.
- Total ban on sale of Gutka has been implemented since 2011. Implementation of COTPA is effective in the State and issuance of challans for smoking in public places have been issued by law enforcement agencies.

DISTRICTS/INSTITUTIONS VISITED

Krishna	Kadapa
Medical College and Hospital Vijaywada	Medical College and Hospital RIMS
District General Hospital, Machilipatnam	District General Hospital Proddutur
CHC Gannavaram, Challapalli, Kanchikacherla	Area Hospital Pulivendula
Ibrahimpatanam, Mopidevi	CHC Pulivendula; Rayachoty; Rajampeta
Sub-Center Poranki-1, Veeravalli, Ullipalem, Mopidevi, Kanuru, Chetuvuru, Tummalapalem, K. Kothapalli	PHC Nandhimandalam; Duvvur;Devapatla; Nandalur
UPHC Chilakalapudi	Sub-Center Thummalaru; G.C. Palle; Guttapalli; Nandalur
Community Poranki, Mopidevi, Kanuru, Punnadipadu, Kothapeta	UPHC YMR Colony; Nakash
VHSNC, Veeravalli	MMU Himakuntla;Yendapalli
UFWC Kothapeta	Community Padda Jonnavaram; Himakuntla; Yendapalli
	School Himakuntla
	ASHA 65

CHALLENGES

- In spite of good RCH initiatives under JSY/ JSSK, deliveries in government facilities have consistently been below 50% of the total institutional deliveries.
- State reports a high number of C-Sections - both in public as well as private sector.
- In public health sector, only 112 out of 265 identified FRUs are functional.
- JSY Payment: Only 5 districts have started DBT linked online payment and over 40% pendency is observed.
- SNCUs have high case load and sharing of radiant warmers by multiple newborns was observed.

BIHAR

REVIEW TEAM

West Champaran	Siwan
Team Leader: Dr. Dinesh Baswal, DC/In Charge (MH), MoHFW	Team Leader: Sh. Sanjay Kumar, DD (MCTS), MoHFW
Dr. Shibu Balakrishnan, RNTCP Consultant, kerala	Dr. D. B. Sarkar, AD (H), AYUSH
Ms. Sucheta Rawat, Consultant, Community Processes, NHSRC	Mr. Ajit Kumar Singh, Consultant-PHA, NHSRC
Dr. Indranil Mukherjee, Public health economics, PHFI	Ms. Indhu S, Manager - RBSK Project, MOHFW
Mr. Mohit Sharma, Senior Technical Officer, National RMNCH +A Unit, MOHFW	Dr P R Sodani, Prof-PH & Health Eco, IIHMR-Jaipur
Dr. Jayendra Kasar, Consultant, NHM, MoHFW	Ms. Risha Kushwaha-Consultant Adolescent Health, MoHFW
Mr. Chander Soni, Consultant- FMG, MoHFW	Sh. Amba Dutt Bawari, US-VBD&CCD,MoHFW
Dr. Gajendra Singh, Health Officer, UNICEF	Dr Vineet Chadha, Head, Epidemiology and Research Division, National TB Institute, Bangalore
	Mr. Rajneesh K Upmanyu, Sr. Consultant NHM-Infrastructure, MoHFW
	Mr. Chander Soni – Consultant- FMG, MoHFW

POSITIVES

- Arogya Diwas: State has integrated the six services; family planning, ANC, PNC, Immunization, nutrition and counselling with VHND.
- AMANAT-B: A State initiative to improve the quality of care especially with respect to Maternal and Newborn Health (MNH) services and Family planning.
- Web based HRIS is implemented in State and transfer of doctors and Staffs are done through HRIS.
- Communicable diseases programme staffs are motivated and committed. DHAPs are in place for all communicable and vector borne diseases. There is visibility of IEC/BCC activities at fields and facility levels.
- State has committed to start life insurance of Rs. 4 Lakh to all ASHAs in the state.
- Sanjivani: Through unique ID a simple module of Hospital Management Information System which has been implemented in all PHCs, RHs, SDHs and DHs in Bihar State from November, 2013.
- State has initiated the process of listing and mapping of notified and un-notified urban poor settlement of 15 cities having population more than 50,000 population.

DISTRICTS/INSTITUTIONS VISITED

Type of Facilities	West Champaran	Siwan
District hospital	DH-Sadar Hospital M. J. K Bettiah	DH Siwan
SDH	1. SDH Bhagha	1. SDH Maharajganj
B- PHC	B- PHC Bairia B- PHC Gaunaha B- PHC Majhauliya B- PHC Narkatiyaganj B-PHC Nautan B-PHC Ramnagar B-PHC Sikta	B-PHC Badharia B-PHC Goriakothi B-PHC Hussainganj B-PHC Jiradei
A-PHC	A- PHC Amulwa A- PHC Bhagha A-PHC Bhaiwarganj A-Valmiki Nagar	A-PHC Kailgarh A- PHC Sisai
Village/ Health Sub-centre	HSC Banchari HSC Bagha-2 HSC Gonoli HSC Kathiya Mathiya HSC Pachrukhiya	HSC Baliyan HSC Jagdishpur HSC Judkan HSC K. Bangra HSC Mahaal HSC Sisai
Other facilities	Maharani Jannaki Kunwar, Medical College	PVM Medical College
Patna	UPHCs, UHND & community groups	
Villages	1. Banchari, 2. Chanpatiya 3. Lovkush Ghat, 4. Lima Pakda 5. Kathiya Mathiya	1. Hathuapancha, 2. Hatta 3. Judkan, 4. Kasdevra 5. Korigoan, 6. Lalahatta 7. Paltuka Hatta
VHSNCs	1. Banchari.	1. Jhanpiya
VHNDs	2. Kathiya Mathiya	
AWW	3. Belwa	

CHALLENGES

- There is no significant progress in increasing the number of delivery points in the districts. There is a significant gap in operational L3/L2/L1 facilities in the state despite this issue being reported in previous CRMs.
- Human resources related issues - cross cutting many national programs- are adversely affecting surveillance programmes.
- Districts are not empowered for deputation of MO within district.
- ASHA training on the ground has slowed down substantially since 2014. Process of MoU with District Training Agencies is pending for one year. Newly selected ASHAs have not undergone any kind of training in the last two years.
- State lacks a routine monitoring & post training supportive supervision system.
- Instead of introducing RCH Register, multiple types of registers (as like old MCH register, FP register, eligible couple registers etc.) were observed to be used at all facilities.
- Huge delay in transfer of funds from State Treasury to SHS i.e. 60-65 days against the prescribed maximum period of 15 days by GOI. Funds for 2016-17 still not received by SHS till November 2016.

CHANDIGARH

REVIEW TEAM

Chandigarh
Dr. Damodar Bachani, Deputy Commissioner (NCD), MoHFW
Ms. Sunita Sharma, Director, NHM
Dr. R. K. Dasgupta, Joint Director, NVBDCP, MoHFW
Sh. Anil H Ramteke, Deputy Director, Statistic, MoHFW
Dr. Ravinder Ahluwalia, Sr. Regional Director, Chandigarh
Ms. Vandana Chaudhary, Under Secretary (Urban Health), MoHFW
Sh Sreedharan Nair, Director External Relation, FPA India
Dr. Rajbhau Yeole, RNTCP Consultant, Maharashtra
Mr. Vindhesh Kr. Singh, Consultant, Finance & Procurment, MoHFW
Ms. Jyoti Jagtap, Consultant, PHP, NHSRC
Mr. Prankul Goel, Consultant, HRH, NHSRC
Dr. Tarun Singh Sodha, Consultant, Maternal Health, MoHFW

POSITIVES

- Line listing of severe anemic women has been done with a very good follow up mechanism. All maternal deaths were reviewed till October 2016. Safe mother group strategy for generating awareness regarding family planning methods is being carried out.
- Cleanliness at all delivery points was observed. SNCU is very well maintained at Sector 16 GSMH.
- Awareness regarding WIFS program is good in schools.
- Immunization services are implemented well in the UT.
- The UT has well established Dengue surveillance system. Currently 4 hospitals have been identified in the city as sentinel hospital for Dengue testing.
- UT has set up well established infrastructure with adequate HR for IDSP.
- Chandigarh has achieved the national level programme indicators of 90% total case notification rate and 90% success rate among new TB cases. The UT received first prize for best performance in RNTCP in Year 2016.
- Good convergence at the Gram level - with PRI representative/ Sarpanch, Department of rural health/ BDPO and Department of Social Welfare representative/AWW.
- VHSNCs are supported by PRIs and are functioning very well for sanitation, declining sex ratio and health in the village.
- ASHAs are working well in close coordination with AWW, ANM, and VHSNC members in the rural areas/ peripheral areas of Chandigarh.
- Zoning of Health Facilities has been implemented under Monitoring & Evaluation/ Health Management Information System for timely data reporting and monitoring the health care delivery services in UT Chandigarh.
- UT reports 100 percent facility wise reporting in HMIS and mapping of facilities also.

FACILITIES VISITED

Chandigarh
Government Multi Specialist Hospital, Sector 16
Alternative Medical Unit - Behlana
Alternative Medical Unit - Khuda Lahore
Civil Hospital - Manimajra
Civil Hospital Sector 22
Urban Primary Health Centre, Dhanas
Civil Dispensary, Dhanas
Rural dispensary, Sarangpur
Alternative Medical Unit, Rural Dispensary, Dhanas
Government Homeopathic & Ayurvedic Dispensary Sec. 47 DO
Maloya Sub Centre
Civil Dispensary Industrial Area, CITCO
Urban Primary Health Centre, Maulijagran
Alternative Medical Unit, Maulijagran village
Govt. Sr. Secondary School, Bahlana
Govt. Model Sr. Sec. School, Dhanas

CHALLENGES

- C-Section rate in UT is high (ranging from 25% to 30% at all the facilities) and referral transport especially drop-back is very weak.
- National Free Diagnostics Service Initiative has not been implemented effectively.
- Single window comprehensive ANC services are not available on PMSMA day. Grievance redressal system under JSSK is non-existent.
- Intra-partum care needs to be improved as most of the cases in the inborn SNCU unit are due to sepsis and asphyxia.
- RBSK teams are not equipped with the necessary equipment. Post referral follow-up mechanism is extremely weak.
- Stock out of IFA (Blue and Pink) tablets was observed in schools under WIFS programme and peer educator programme yet to be implemented.
- The UT does not have any HRMIS but it is planning to adopt Manav Sampada application being used in Himachal Pradesh and developed by National Informatics Centre.
- No meeting of SQAC has been conducted. Road map for Quality Assurance has not yet been decided.
- There is lack of training to the finance and accounts staff at sub-district level, leading to inadequate understanding of financial guidelines and relatively weaker financial management at the CHCs/ PHCs and lower level.
- The UT has not taken any steps to rationalize the existing human resource within the health department and new recruitments either.

DELHI

REVIEW TEAM

Shahdara	Central
Dr Kalpana Baruah, Joint Director, NVBDCP, MoHFW	Dr Sumita Ghosh, DC(MH-I), MoHFW
Dr Zakiuddin Ali Khan, Dir-AYUSH	Ms Deepti Srivastava, Director, MoHFW
Ms Seema Upadhyay, Prog Manger-AGCA Secretariat	Dr Deepika Singh Saraf, Sceintist-E-ICMR
Mrs V K Bhalla, US-NRHM-I	Dr Madhuchhanda Das, Scientist-C-ICMR
Dr Anju Pradhan Sinha, ICMR	Dr. Prashant Soni, Consultant, CH
Sh Raghunath Prasad Saini, RCH	Ms Namita Gupta, AHS
Ms. Sagarika Kalita, Consultant-HMIS, NE-RRC, NHSRC	Dr. Padam Khanna, Sr Con, PHP, NHSRC
Dr Raj Panda, PHFI	Ms. Neha Kashyap, Consultant, NHM
Dr Priyanka Agarwal, RNTCP Consultant, Punjab & Chandigarh	Sh Yogesh Chandra, FMG
Ms. Sudipta Basa, NUHM	

POSITIVES

- UT has established free drugs and diagnostics services in public health facilities. There is an EDL of 1417 drugs with flexibility to the facilities for choosing required drugs as per their specific caseload and update their respective facility wise EDLs from time to time depending upon requirements.
- UT is providing Dialysis services at LNJP and GTB Hospital free of cost for BPL families/ at nominal charges for APL patients.
- The unique "skill lab" training facility for hands-on training and IVF center in LNJP is amongst the best in the country.
- The AYUSH system is very well integrated within National Health Mission with AYUSH doctors are trained and providing services in all health programmes e.g. RMNCH+A and NLEP.
- The mobile dental clinics initiative is a good step for providing preventive and curative services.
- There is a state of the art CATS control room for managing emergency transport of patients.
- UT has a cadre specific assessment system for contractual staff and human resource information system is in place covering all the facilities and every cadre functional in these facilities.
- Information systems HMIS, MCTS (RCH) and PFMS are well placed along with requisite IT infrastructure.
- Review of health programmes including DSHM activities is done by Chief Minister and Health Minister.

DISTRICTS/INSTITUTIONS VISITED

Shahdara District	Central District
GTB Hospital	LNJP, Kasturba Hospital
RG Canncer Hodpital	Majnukatila- DGD
Dr. Hegdewar Hospital	Burari MCW
SDN Hospital, IHBHAS	Kamla Nehru maternity
Polyclinic- Kantinagar, Nandnagri	NC Joshi Hospital
UPHC- Amar Colony	Ramakrishna Chest Clinic
Maternity home- Seelampur, Chandiwala	AAMC- Nathupura, Majnuka Tila
DGD- Sundernagar, Karkardooma, New Lahori Colony	Central Procurement Agency,
East Delhi Municipal Corporation,	CATS
Mother Lab- Nandnagari, Karkardooma	Burari Hospital (under construction)
AAMC- Meetnagar, Rohtasnagar, Seelampur, Sundernagar	Delhi State Cancer Institute
	Mobile Dental units
	Tibia Hospital

CHALLENGES

- The drug storage lack enough space for organizing different batches of drugs and dispensing as per FIFO/ FEFO. Manual indenting of drugs below the Hospital Drug Store level. No mechanism to take stock of drugs lying at the various departments of hospital and facilities.
- The prescription audit mechanism is nonexistent in the facilities.
- No Centralized equipment maintenance system at the UT level.
- The National Vector Borne Disease Control Program (NVBDCP) is the most neglected programme at district level, with weak coordination between DHS and municipality

GUJARAT

REVIEW TEAM		
Dr P K Prabhakar (Team Lead)	Dr Jyoti	Dr Chakrapani Chatla
Dr Satyajit Sen	Mr. Daman Ahuja	Mr Sumanta Kar
Dr Tapas Chakma	Mr Deepak Kumar	Mr Tushar Mokashi
Dr Janardanan Nair	Dr Irina Papieva	Mr Mayank Sharma
Dr Joydeep Das	Ms Richa Shankar	Dr Seema Pati

POSITIVES

- There is good coordination and synergy among various units including medical education, urban health and other different departments.
- Kayakalp is being implemented at all levels and general maintenance of buildings was excellent.
- Monitoring systems including e-MAMTA are in place.
- Pace of implementation of NUHM is satisfactory in the districts visited.
- Strong private sector presence and effective PPP models.
- State initiatives like Free Diagnostics under the Mukhya Mantri Nidan Yojana are effectively implemented.

DISTRICTS/INSTITUTIONS VISITED

Gandhinagar	Navasari
1. GMERS and District Hospital	District Hospital Navsari
2. Sub district hospital- MANSA	Sub district hospital- cottage hospital vansda
3. CHC - Adaraj, Dehgam	CHC - Chikli, Khergam
4. PHC - Unava, Devkaran Muvada, Pundhara, Saij, Rancharda, UPHC (Sec 29), UPC 1 (Kalol)	PHC - Hond, Toren vera, Dhanotri, Vesma Urban, Dusherra Tekri, Kandolpada, Bahed
5. Sub Center – Pethapur, Rancharda, Palsana	Sub-Center - Dholumber, Vad, Raniphariya
6. MAS Group Jilhan, MAMTA DIWAS	MAS Group
7. AWW Centre (Village Vadsar, Arjanna Muwada)	
8. Pradhan Mantri Surakshit Matritva Abhiyan	Pradhan Mantri Surakshit Matritva Abhiyan
9. Sanidhya Multispeciality Hospital (Chiranjeevi)	Gram Sewa Trust Hospital Kharel (Chiranjeevi)
10. RPMU, DPMU, SHS, GVK EMRI Facility	DPMU, Mobile medical unit
11. Collector cum District Magistrate Gandhinagar	Collector cum District Magistrate Navsari

CHALLENGES

- Under-utilization of public health facilities and sub-centres not developed as delivery points.
- Blood shortage in Blood Bank and BSUs was reported. Monitoring of license renewal, etc. for blood blanks is weak. Also high C-section rates (District Gandhinagar) were reported.
- Inadequate utilization of RBSK teams in PHCs was observed.
- Weak implementation of NOHP with irrational deployment of resources.
- HRMIS used for the regular cadre staff yet to be implemented for NHM employee.
- Shortage of specialist cadre at all levels of care, throughout the State.
- Physical Reporting in FMR is not made by the State to GoI even though it is ROP conditionality.

HIMACHAL PRADESH

REVIEW TEAM

Team Leader - Shri Oma Nand

Mandi	Solan
Dr J N Srivastava, Advisor QI, NHSRC	Dr Bamin Tada, Director, NE-RRC, NHSRC
Dr Himanshu Chauhan, DADG(NCD/HC), DGHS	Dr Naina Rani, WHO
Mr Vikas Sheemar, AH	Dr B S Arya, AD(H)- AYUSH
Dr Dhrubajyoti Deka, RNTCP Consultant WHO, Assam	Ms Meera A P, DD-Stats MoHFW
Ms Vinita Srivastava, Blood Cell, NHM	Dr Abhishek, Regional Director, Shimla
Mr Prashant Kumar, FMG	Dr Ravish Sharma, CH
Ms Bhanu Priya Sharma, NHM	Dr Sushant Kumar Agrawal, QI NHSRC

POSITIVES

- State has made efforts to reach unreached sections of population through telemedicine which is being implemented through PPP (with Apollo) in Lahaul Spiti, Chamba and Sirmaur Districts; Telestroke in collaboration with AIIMS including 17 Primary Stroke Centers and two comprehensive Stroke Centres at IGMC &RPGMC.
- Three District Hospitals Nahan, Chamba and Hamirpur have been upgraded to Medical Colleges.
- State has initiated online blood bank management information system, which provides live availability of blood stock across all the district blood banks, blood group stock and also provides the list of blood donors registered with the district blood banks.
- Himachal Pradesh has overall good family planning indicators with TFR of 1.7 and CBR of 16.4. The State has effectively implemented the Family Planning program.
- "State Nutrition Mission" has laid the foundation for good IYCF practices and improved nutrition.
- All the antenatal cases were being tested for HIV and Syphilis which shows good integration of PPTCT Programme with Maternal & Child Health services.
- VHSNCs are regularly receiving VHSNC grant. More than 50% women representation is seen in VHSNC.
- 96% health facilities have been mapped under HMIS.
- 9. Quarterly reviews are being done at State Level and Monthly Review at District Level, Block Level and supportive supervision are done by State Program Officers and BMO.

DISTRICTS/INSTITUTIONS VISITED

DH	2	RH Solan	ZH Mandi
CH	4	CH Kunihar, CH Arki	CH Sundar Nagar (FRU), CH Karsog
CHC	3	CHC Dharampur	CHC Bagsaid, CHC Janjehli,
PHC	7	Battal, Domaher, Sultanpur, Pattamahlog	Thunag, Pangna, Palli
SC	7	SC Ghajar, SC Bohli, SC Bakhalag	SC Lambchafad, SC Chindi, SC Gumanu, SC Bakhrod
Schools	3	GSSS Dharampur,	GSSS Bangrotu, GSSS Baddi
AWW	3	Sihari Chamari	Chindi, Bakhrod
FGD conducted	3	Bohli	Mahila Mandal Chindi PRI Pangna
Others	12	GVK EMRI Centre, 104 Centre, TB Sanatorium, Leprosy Centre, BMO Office of Dharampur and Arki, ASHA of various Areas, PMSMA at RH Solan	Birth Waiting Home, BMO Office Bagsaid and Janjehli, Ayush Hospital Karsog, ASHA of various areas

CHALLENGES

- Despite the dedicated PWD system in place, progress is slow and state needs to expedite ongoing constructions.
- The OPD and IPD footfalls are concentrated at regional hospitals and to some extent at block level CHCs and were least in sub-block level PHCs.
- The State has rolled out a 56 essential drugs and 10 consumables free policy to all patients across public facilities. However, out of pocket expenditure on medicine has been reported as most of the medicines prescribed are not from the enlisted free medicines.
- Drug inventory management system at facilities needs attention from the higher levels.
- HP government entered into partnership with SRL labs to provide diagnostic services in 12 district hospitals and those with 100 bedded with high footfalls. However, this resulted in almost defunct of existing in-house lab that needs to be reviewed critically in terms of number of LT employed in the lab and number of diagnosis done over a period of time.
- There was no involvement of the AYUSH doctors in the running of the national health programmes. Contractual AYUSH MOs engaged under NHM at co-located facilities were observed to be involved mainly in task shifting of allopathic doctors. Further, shortage of AYUSH drugs and non-availability of AYUSH pharmacists have been observed as bottlenecks in ensuring availability of AYUSH services in the co-located facilities.
- Awareness and utilization of JSSK for the treatment of sick infants was found to be low. Out of pocket expenditure was observed by team members on Ultrasound in Solan District during ANC by beneficiaries amounting to Rs. 300/- to Rs. 1000/- and on drugs (ranging from between Rs 1400 to Rs. 3000/-).

JHARKHAND

REVIEW TEAM

Lohardaga	Dhanbad
Dr. Devesh Gupta (Team Leader)	Dr. Sukhvir Singh
Mr. Biswajit Das	Dr. Kailash Kumar
Mr. Prasanth K.S.	Dr. Amit Karad
Dr. Imran Farooq	Dr. Subrato Palo
Mr. S. Nayak	Mr. Samarajit Chakraborty
Mr. Shivam	Mr. Syed Mohammad Abbas
	Mr. Shabeer

POSITIVES

- Good OPD footfalls and delivery load in public health facilities.
- MMU well deployed with availability of OPD services.
- AYUSH resources are available and well utilized under RBSK
- Good availability of drugs with EDL and indenting mechanisms in place and MCH initiatives such as JSY, JSSK are well implemented.
- Services such as NBCC, Interval and postpartum IUCD insertion, and Comprehensive Abortion Services are established and functional in most facilities.
- The 'Sahiyas' are well informed and aware about their roles, responsibilities and are committed.
- Well functional UPHCs and MAS.
- All the key IT based monitoring systems HMIS, MCTS and PFMS are well established; HMIS data is available and matches with the primary registers.
- All the mandatory audit procedures like Statutory, internal, concurrent & CAG Audit are conducted.
- Implementation of Clinical Establishment Act (Notification of an appropriate authority and Registration) is appreciable.

DISTRICTS/INSTITUTIONS VISITED

	Garhwa	Godda
1	District Hospital, Garhwa	District Hospital, Godda
2	CHC: Meral, Bhandaria, Dhurki, Majhiaon	CHC: Sundarpahari, Meharma
3	PHC: Ramkanda, Urban PHC Tandwa, Chataniya, Danda	FRU: Mehagama
4	HSC: Sagma, Tatidiri, KaruaKalan	PHC: Dhamruhatt
5	VHND: Gaheri, Ramkanda	HSC: Khattona, Chanda, Kad Khadiya
6	Village: Lakhna, Tandwa-Ward 7&2 (Slum)	VHND & PLA: Podiyahatt
7		Village: Meharma

CHALLENGES

- Patient transport services are available but no ambulance was providing even BLS services and inefficient planning for RMNCH+A institutions (shortage of L3 and 24X7 PHCs)
- Inadequate counselling services especially for RMNCH+A services and weak referral and follow up mechanisms under various programmes, e.g. RBSK.
- Process of prescription audit has not yet initiated and there is weak supply chain system, especially in peripheral facilities, leading to stock-outs (condoms and other FP commodities).
- Bio-medical Equipment Maintenance programme, National Free Dialysis Programme, and initiatives such as mechanised/ outsourced laundry are not implemented. Also, there is no policy of condemnation of junk materials, thus resulting in huge wastage of space in service areas.
- No target based planning for NPCDCS programme for establishing District based NCD clinics and there is little effort to improve community awareness regarding cancer & tobacco control activities.
- Payments for Sahaiya incentives are irregular in certain Blocks, also Sahaiya drug kits are unavailable and need replenishment.
- Most of the VHSNC in the state have been reconstituted but training is yet to be conducted, with VHSNC members not participating in key activities such as VHND, village heath plan preparation and community monitoring. Members are also not aware of the roles & responsibilities, provision and usage of untied funds.
- RKS has not been reconstituted in many facilities and meetings are irregular (District Godda), and participation of the members from other departments is negligible. Existing RKS members are not oriented about their roles and responsibilities for RKS.
- No grievance redressal system has been established yet.

JAMMU AND KASHMIR



REVIEW TEAM	
Anantnag	Ramban
Ms. Rathi Balachandran, MoHFW- Team leader	Dr. Satish Kumar, NHSRC- Team leader
Dr. N. Sarojini, MSG/SAMA	Dr. Sonia Luna, NHSRC
Dr. Shazia Wafai, DGHS	Ms. Jenita Khwairakpam, MoHFW
Ms. Renuka Patnaik, MoHFW	Dr. Tanu Kathuria, NITI Aayog
Dr. I. I. Meshram, ICMR	Ms. Lakshmi Parvathy, NITI Aayog
Lt. Aseema Mahunta, MoHFW	Mr. Manoj Kumar, NHSRC
Ms. Sweta Roy, TSA	Dr. Sandeep Chauhan, WHO (UP)
Mr. Prabhash Jha, MoHFW	Mr. Ritesh Aeron, (ePMU) MoHFW

POSITIVES

- Overall physical infrastructure is satisfactory.
- Drugs procured through J&K Medical Supplies Corporation Limited are tested for quality check before distribution.
- All delivery points visited are functional with availability of essential drugs. NBCCs were observed to be functional.
- There is adequate supply and distribution of contraceptives. Total unmet need for FP methods shows a declining trend.
- Diagnostic services for RNTCP were available free of cost to the community and all the Laboratory Technicians (LT) of DMCs visited were trained in RNTCP.
- State has adequate number of sanctioned positions of technical staff as per IPHS. The available healthcare manpower is providing uninterrupted services irrespective of the difficult situations, turmoil and difficult terrain
- Simulators to train Medical, nursing, paramedical and other health workforce are in place in RIHFW, Kashmir division. Regular training on BLS course for Doctors, Nursing Paramedics etc., and Emergency Room Trauma course (ERTC) for Doctors and Technicians, Advanced Cardiac Life Support (ACLS) course for Doctors are conducted at Kashmir division. Skill Lab has been established at RIHFW Kashmir.
- ASHAs are active, enthusiastic, vibrant and knowledgeable and low dropout rate observed in both the districts. State and district has good ASHA support structure in place.
- The triple AAA platform is functioning well and there is good coordination observed between AWW, ANM and ASHA.
- Facility-wise data entry across state seems stabilized in HMIS Web Portal and monthly facility performance data was available in the visited facilities. Line listing of severe anaemia is being done and records maintained.
- All the payments towards ASHA incentive and JSY beneficiary are being paid through DBT using PFMS. E-transfer at all facilities are followed and no cash transactions are taking place

DISTRICTS/INSTITUTIONS VISITED

Type of Facilities	Anantnag	Ramban
DH & MCH centre	DH and MCCH	DH
CHC / SDH	1. Shangus 2. Dooru 3. Bijbehara	1.Banihal 2. Batote
PHC / UPHC	1. Nawgm 2. Verinag 3. Mattan 4. Nathpura - UPHC 5. Donipawa - UPHC 6. Pehru - UPHC	1. Ukhral 2. Ramsoo 3. Sangaldan 4. Trigam 5. Bhatni 6. Chanderkot
SC	Cherpura, Nawgm, Akura, Andoo	Kaskoot, Kanga, Thopal, Basan, Maitra, Pernote
Schools/ Training Centre	ANMTC, Anantnag RIHFW, Dhobiwan, Baramulla District TB Centre, Anantnag	• Govt. Girls and Boys School, Maitra • Primary School, Thore • Govt. High School, Govt. Middle School, • Private School, Ramsoo • District TB Centre, Kishtwar
AWC	Akura and Andoo	Shanar, Dharmod
Villages/Societies	Cherpura, Nawgm, Akura and Andoo	Chandrog, Basan, Maitra, Thopal, Ukheral, Banihal, Local Trade Organisation, Banihal
State	J&K Medical Supply Corporation Ltd., State Drug Ware House, Bathindi UPHC-Jammu,	

CHALLENGES

- None of the FRUs are fully functional in Ramban district due to lack of Blood Bank/BSU and Paediatrician.
- Prescription audit mechanism and grievance redressal mechanism is completely non-existent in the State.
- Free Diagnostic scheme is yet to be implemented in the State.
- Underutilization of ambulances - on an average one ambulance is making less than one trip/day was observed.
- Fixed day, fixed place and fixed time approach not implemented for MMU.
- Spacing methods have not picked up particularly IUCD and PPIUCD. Fixed day services for sterilization are not available and consent forms are not being utilized as per GOI norms.
- Inadequate focus on adolescent health issues was observed and WIFS was not implemented.
- RNTCP programme is functional vertically and is not fully integrated with NHM.
- National Dialysis Service Programme is not rolled out in the district.
- VHSNC members in Ramban are not aware of untied fund provided by the Union Government. Fund disbursement to VHNCs is not in place from last 3-4 years. There was delay of 5-6 months towards JSY payment to beneficiaries in both the district for the FY 2016-17.
- Validation / authenticity of data uploaded in HMIS and MCTS application was very limited because of inadequate monitoring at supervisory level and above and gaps in the understanding of the data elements in these systems.
- 18001800102 and 18001800104 were stated as operational for managing grievances and validating service deliveries. However, no IEC was observed at the facilities.
- Convergence is weak amongst Health department, ULBs and other departments like WCD (ICDS) Sanitation, PHE, Social Welfare, School Education, e.g. as per records no convergence activities have been initiated so far with ULBs. There is no integration with other National health programmes.
- RKS in the UPHCs have been formed recently and they are presently non-functional. In the State only 57 % of the total RKS approved have been formed. No training and capacity building activities have been carried out for MAS members.

KERALA

REVIEW TEAM

Idukki	Kollam
Dr Sila Deb, Deputy Commissioner, MoHFW (Team Leader)	Dr Ranjana Garg, Asst Commissioner, MoHFW
Mr Vibeesh EM, SRO, NITI Aayog	Dr A Raghu, Deputy Advisor, AYUSH
Dr Biraj K Shome, Consultant, NE-RRC	Mr Kedarnath Verma, Dy. Director, MoHFW
Dr Mahaveer Golechha, IIPH Gandhinagar	Dr K. Rahul S Reddy, Sr. Consultant, NHSRC
Dr Yogesh Patil, RNTCP WHO Consultant, Gujarat	Mr Ratish Kumar Manjhi, Consultant (AH), MoHFW
Dr Bhrigu Kapuria, Immunization Specialist, UNICEF	Dr Jai Kishan, Asst Professor, NIHFW
Dr Swati Mahajan, Associate Director, Jhpiego	Dr Joe Varghese, Senior Research Scientist, PHFI
Ms Shalini Rao, Sr. Consultant, TSA	Ms Tanushree Sahu, Consultant, MoHFW
Mr Jayant Mandal, Finance Controller, NHM-FMG, MoHFW	Ms Saranga Panwar, Consultant, MoHFW

POSITIVES

- Integration between the Directorate of Health services and National Health mission is commendable. The District Programme Managers are appointed from the regular Medical Officer cadre from DHS, which has helped in their sustainability, and better understanding of the public health issues for taking appropriate measures in time.
- Strong presence of Local Self Government in supporting the facilities by contribution of funds for infrastructure, drugs etc. and close monitoring of functionality has added a positive dimension in health care delivery of the State.
- Innovative activities are in sync with emerging health needs (NCD clinics up to PHC level, palliative care, autism clinic etc.)
- Efforts are on to add modern diagnostics and treatment facilities at District level including dialysis, MRI and cancer care.
- Utilization of AYUSH system is good and the demand for AYUSH services should be matched with strengthening it with adequate HR, expansion of infrastructure, bringing in quality research opportunities for evidence based care and expanding the scope of preventive and rehabilitative AYUSH services in view of increasing NCD burden.

DISTRICTS/INSTITUTIONS VISITED

Type of Facilities	Idukki	Kollam
District	DH Thodupuzha, Idukki	DH Kollam, Victoria Hospital
THQH	THQH Adimaly	Karunagappalli, Punaloor
CHC	Muttom, Marayoor, Vandanmedu, Chithirapuram	Alappad, Palathara
PHC	Kumbli, Vellathooval	Vallikkavu, Mundro, Parippalli, Adichanalloor, AchanaKovil, Mancode Chithara
UPHC	UPHC Thodupuzha	Karunagappalli, Vadi
Sub Centre	Munnar town, Seven Malai, Periyavarai, Nallathanni, Painavu, Mattupetty, Kathipara, Attukad, Powerhouse	Mekkonne, Mundro Island, Kizhakumbhagam
AYUSH Facilities	District Ayurveda Referral Hospital Thodupuzha, District Ayurveda Hospital Painavu	District Ayurveda Hospital District Homeo Hospital Ayurveda dispensary Ayur, Siddha, Homeo Dispensary, Mundro Island Anchal, Chirakkara, Adichanalloor
Others	SPMU, SIHFW, KMSCL, DPMU PH Lab at Kollam, District TB Centre, Chest diseases hospital Karunagappalli District Drug Store, F&W Centre, Mobile Medical Unit Kulathupuzha Day care Centre for mentally challenged patients, Schools, Anganwadis PRIs – District/Block/Gram Panchayats, Corporation & Municipality Migrant screening site: Estate hospital (east division), Kanan Devan Hill Plantation (KHDP) Govt. VHSS and TTI Munnar School, Govt. School of Nursing Muttom	

CHALLENGES

- State has not made higher fund allocation for the High Priority Districts.
- The CHCs and PHCs in the State are mostly underutilized in spite of adequate infrastructure.
- There is inadequate sanction of HR for higher level facilities and CHCs and irrational deployment of existing HR without taking the load at facilities into consideration.
- There were instances of shortages of essential drugs at facilities & warehouses. Also, distribution of drugs from warehouses before receiving quality test report from KMSCL empaneled labs is a concern.
- Standard Treatment Guidelines and Management were not available or adhered to, especially for in-patients suffering from childhood illnesses.
- Non availability of dedicated ambulance services for transportation of patients to facility and back continues to be an issue of concern from previous CRMs, despite the increasing burden of trauma cases and failure to provide the entitled transportation facility under the JSSK.
- Even though UPHCs were functional, they were found not implementing national programs for disease control.
- Untied funds were not distributed to peripheries despite approval in 2015-16. In-effective concurrent audit mechanism is observed.

MADHYA PRADESH



REVIEW TEAM	
Dindori	**Ratlam**
Dr. Himanshu Bhushan, Advisor, NHSRC	Dr. Nikilesh Chandra (Sr. RD RoHFW)
Dr. S.C. Agrawal (DD BOP)	Mr. Alok Kumar Verma (Dir Stats)
Dr. Nilesh Deshpande, UNFPA	Dr. Sharmila Neogi (USAID)
Dr. Prem Singh, UNICEF	Dr. Bhaswat Das (Sr. Consultant NERRC)
Ms. Nirmala Mishra, PHFI	Dr. Dipak Ganvir (NIPI)
Dr. Sheena Sara Philips, NITI Aayog	Dr. Ashish Chauhan (Cons. Immunisation)
	Dr. Kshitij Khaparde (WHO)
Mr. Akhilendra Trivedi, AHS MoHFW	Ms. Tejinder Kaur (FDA MoHFW)
Dr. Krishna Sirmanwar, (Cons. NHM MoHFW)	Dr. Adil Shafie (Cons. NUHM, MoHFW)

POSITIVES

- Low OOPE reported by patients and beneficiaries.
- Systemic appraisal of contractual and adhoc staff is being done by State. All TORs and job responsibilities are formulated and available on NHM MP web site.
- Most of the labour rooms in the district are well equipped with logistics and trained HR and are following GoI protocols.
- Cold chain is being maintained through eVIN system with digital logger and alarm system for temperature monitoring.
- All the drugs are subjected to three layered quality check before being released for use by facility.
- Chetna, a mobile application, has been launched recently for screening, line listing and referral of children by RBSK teams.
- There is inter-sectoral convergence in malaria control and IEC.
- Good Treatment Success Rate (90%) in RNTCP.

DISTRICTS/INSTITUTIONS VISITED

Type of Facilities	Dindori	Ratlam
District level	District Headquarter (CMHO office), District Hospital Dindori, SNCU Dindori, NBCC, NRC Dindori	District Hospital, Civil Hospital, SNCU, ETAT, NRC
Block level	CHC Samnapur, CHC Karanjia, CHC Bazak	CH-Jaora, CHC Namli & Bajna
Sector/PHC level	GouraKanheri, Gada Sari, Amarkantak	PHC-Raoti & Sarwan
UPHC	--	Dilip Nagar, Hakim wara, Jaora, TIT Road. (2 UPHC from Bhopal)
Sub Centre level	Kanchanpur, Raipura, Kunda, Jalda Bona	SC-Chawrakhedi, Makodiarundhi, Nayan & Rajapuramataji
VHND/AWC	Sadhu Ram Tola, Bondar, Ramnagar	Nayan, Bherupada
Villages	Kanchanpur, Raipura, Bondar, Sadhu Ram Tola	Nayan, Ballipada, Devipada
Others	Elgen Hospital Jabalpur & Nursing College, Jabalpur	

CHALLENGES

- High unreported home deliveries, Dindori (31%) and Ratlam (25%), but no systemic approach to track.
- Maternal death review & child death review is limited to clinical cause and systemic gaps are not being identified.
- Long questionnaire and verification for 108 call (12 mins) and inadequate knowledge levels in EMTs.
- Integration for all type of counsellors (except RKSK), however, lack of standardized counselling material diluting the quality of counselling.
- Block Medical Officers do not monitor the implementation of program and their awareness on the same is also not adequate.
- The State is giving performance based incentives in 17 HPDs but this has not resulted in increase in number of the Specialists.
- The same tender for hiring of vehicle at both in District and at State level is being renewed since the last financial years.
- Delay in dissemination of the approvals to the districts. State received the approvals in May 2016 but conveyed them to districts in August 2016.
- Inadequate HR at UPHCs, RKS not constituted, and inadequate convergence with ULB for preparation of city health plans.

MAHARASHTRA

REVIEW TEAM

Nashik	Nagpur
Dr. Basab Gupta, MoHFW (Team Leader)	Dr. Zoya Rizvi, MoHFW
Dr. S.N. Sharma, MoHFW	Dr. Raghuram Rao, MoHFW
Dr. Devina Bajpayee IPE Global	Prof. Surinder Jaswal, TISS
Dr. Kirti Iyengar, UNFPA	Dr. DK Raut, FWTC
Dr. Megha Khobragade, MoHFW	Dr. Dinesh Jagtap, GoI
Dr. Neeta Rao, USAID	Ms. Aastha Sharma, NHSRC
Dr. Satya Lenka, WHO	Ms. Manjari Sharma, MoHFW
Ms. Monmayuri Dutta, MoHFW	Mr. Prabhat, NHSRC
Mr. Gyanish Kumar, MoHFW	

POSITIVES

- State has robust free drugs services and bio-medical waste management services.
- State also has comprehensive ANC services, PHCs/SCs serving as delivery points with clean well-arranged LRs, and birth companion programme successfully running.
- Staff knowledge on evidence-based practices was good.
- JSY and JSSK implementation and coverage are also commendable. PMSMA has been rolled out in tandem with Matritva Din.
- Active and passive surveillance is regularly carried and the overall reporting & monitoring mechanisms are well established.
- Under PMDT services have been rolled out in entire state and specific expensive diagnostic tests for TB are available at facilities free of cost.
- State has also initiated opportunistic screening for hypertension and diabetes upto PHC level (with variable coverage).
- Grievance and crisis helpline 104 is displayed even at the SC level.
- State has a system of regular skill based competency assessment during recruitment of Medical officers and paramedical staff.
- The SIHFW/PHI is well equipped with sufficient infrastructure, staff and training aid.
- State has a well-managed ASHA Programme.
- Well established strong systems of coordination, planning and supervision at the District level.

DISTRICTS/INSTITUTIONS VISITED

Type of Facilities	Nashik	Nagpur
District Hospital	Nasik	Daga Women's Hospital
Sub-District Hospital	Kalwan SDH Malegaon SDH	Ramtek SDH
Community Health Centre	Peth Trimbak Chandwad	Rural Hospital Umred FRU
Primary Health Centre	Umrale, Karanjali, Lohaner Uswad, Amboli Karangavan, UPHC - Malegaon UPHC - Maiko Saatpur UCHC - Swami Samarth	Makerdhokada (24X7) Bhandarbodi, Takalghat Umred - UPHC Phutala - UPHC Zingabai Takli - UPHC
Sub Centre	Anjaniri, Mangrood, Talwade, Shinde, Vitewadi	Malewada (Bhivapur), Navegam Sadhu Musewanda, Umri, Rohda
School	Waghera	Closed for Diwali
Others	Palliative Centre-Igatpuri Anganwadi, Village-Karangavan & Waghera, Elected Bodies, Corporates, FW Training Centre	Medical College State TB Training Institute STDC & IRL PHI and H&FW Training Instt Regional Mental Hospital

CHALLENGES

- Poor IEC for referral services among beneficiaries.
- Beneficiaries not informed on all options for family planning services.
- Differential planning for CEmOC services is lacking.
- Very high bed occupancy in SNCUs in DH (250%), due to underutilization of stabilization units.
- Weak referral and follow up mechanism of neonates/ children discharged from SNCUs/NRC.
- NCD clinics yet to be established at higher levels of care. Also, IEC for cancer prevention and care needs strengthening.
- Cash books are signed by a single person, but should be signed by at least two persons. SHS should issue a clear guideline regarding this.
- The supportive supervision and monitoring visits are sub optimal and need strengthening.
- RKS GB and EC members do not meet regularly, untied funds mostly used for procuring stationary and equipment. District Collectors does not monitor health programmes in many instances.

NAGALAND



REVIEW TEAM

Mon	Tuensang
Dr Teja Ram, DC (FP), GOI	Dr Pushpanjali Swain, Professor-NIHFW
Dr L A Singh, RD, GOI	Dr M Prakasamma, AGCA Member
Dr Mohan Bairwa, Asst. Prof. (IIHMR)	Dr. Parminder Gautam, Sr Consultant, QI, NHSRC
Dr. Amit Harshana, Consultant, Immunization, MoHFW	Dr. Vineet Goyal, Associate Advisor (ITSU-PHFI)
Dr. Madhusudan Yadav, Consultant-PHP, NHSRC	Dr Narender Goswami, Consultant, MH, MoHFW
Ms. Priyanka Grover, Consultant, FMG	Dr Manorama Bakshi, NRU
Ms. Asmita Jyoti Singh, Senior Consultant (NHM), MoHFW	Ms Simi Thambi, Young Professional-NITI Aayog

POSITIVES

- Good infection control practices and CSSD at District Hospital.
- Involvement of community in infrastructure development and demand generation for services.
- State has passed 'The Nagaland Communitisation of Public Institutions and Service Act 2002' to enable empowerment of the community for effective delivery of various services including health services.

DISTRICTS/INSTITUTIONS VISITED

Level	Senapati
CHC - Aboi	CHC - Noklak, Longkhim
DH - Mon	DH - Tuensang
SDH	SDH -
PHC – Angphang, Phomching, Tizit, Wakching, Chen	PHC - Noksen, Tuensang, Pangsha, Longpang
SC-Tanhai, Angjangyang, Wangla, Longchang, Longwa, Zakphang, Chang	SC - Sang Sang Yu, Hackchung, Tronger
Chingnyu, Mission centre	CMO and DPMU Office
Government school- Wangla Chingnyu	government School- Noklak Government High School, GPS High School Tuensang Village
Anganwadi centres	

CHALLENGES

- Inordinate delays in transfer of funds from Treasury to SHS were seen.
- High Out-of-Pocket Expenses (including JSSK) being incurred by community.
- Irrational deployment of human resources throughout the State.
- Lack of any functional FRU in any of the district visited in the CRM.
- Ineffective and inefficient drug procurement and supply chain management.
- Huge gap in training and capacity building was observed for technical as well as non-technical cadre.
- State does not have any decentralized planning system and there is no use of available data or evidences from field for effective planning.

TAMIL NADU

REVIEW TEAM

Thirunelveli	Namakkal
Dr M K Aggarwal, DC (Imm-UIP)	Dr Sanjiv Kumar, ED, NHSRC
Dr Leela Visaria, MSG Member	Dr Roshini Arthur, Sr RD-Chennai
Dr N. Arlappa, Scientist - E-ICMR-Hyd	Dr P Sathiyarajeshwaran, AD-AYUSH
Ms Amita Chauhan, NHM	Shri S.Natarajan, DS-VBD&CCD
Ms Isha Rastogi, NUHM	Ms Rita Pradhan, RRC NE (NHSRC)
Dr Pranav Bhushan, NRU	Sh Rahul Govila, FMG
Dr Sridhar Ryavanki, UNICEF, Assam	Dr Javvad Suri, IPE Global
Dr Rajendra Panigrahi, RNTCP Consultant, Orissa	
Ms Samina Parveen, PHFI-IIPH, Shillong	

POSITIVES

- State has a well-established health infrastructure and adequate number of Public Health Institutions at all levels of care.
- Diagnostic services are available 24X7 and are free of cost except for CT & MRI, for which minimal charges are levied. State model of providing Free Diagnostics Services is completely run by Government through TNMSC.
- Blood banks are having necessary IT logistics and are well connected with internet and information regarding availability of stock of blood units are available on web site.
- There is a very good coordination of health department with the ICDS.
- 108 ambulances with a dedicated toll number are strategically located and are used to pickup pregnant women and sick children from home to the facility and for inter facility transfer.
- Identification and line listing of all High Risk Pregnancies (HRPs) are available at all levels of care.
- The state has robust maternal death review mechanism. However, the State is yet to initiate the implementation of Maternal Near Miss Review.
- There is a steady decline in trend of Dengue and Malaria cases from 2012 to 2016 and substantial reduction in dengue deaths. In the State, no case has been reported of Malaria Mortality from 2012 onwards which is appreciable.
- Under NPCDCS the State Cancer Institute (SCI) / Tertiary Care Cancer Centre will provide comprehensive cancer diagnosis, treatment and care services.
- State has Medical Recruitment Board (MRB). Doctors are not taken on contract but directly on time scale.
- Tamil Nadu has a very robust information and management system. Data is collected on time with the help of clear time lines. Data received is analyzed and used effectively for planning and monitoring, and timely, corrective feedback is provided at all levels.

DISTRICTS/INSTITUTIONS VISITED

Type of Facility	Tirunelveli	Namakkal
Medical College	Medical College Tirunelveli	-
District Hospital	Tenkasi DH	Namakkal DH
SDH	SDH Nanguneri	Thiruchengodu SDH
CHC	CHC Pattamadai, CHC Kuruvikulam and CHC Thisayanvilai	Valavanthinadu CHC & Ernapuram CHC
PHC	Achanpudur Additional PHC, V.K. Puram Additional PHC, Vannikonendhal Additional PHC	Manickampayalayam PHC, Periyamandi PHC & Powerkadu PHC
Sub Centre	HSC Kooniyoor, HSC Pazhamkottai, HSC Palankoti	Kulivalavu HSC, Mavureddipatti SHC, Aniyar HSC & Perumapatti HSC
NUHM	Tirunelveli corporation, Urban PHCs Pettai under Municipal Corporation	Namakkal UPHC, Mudaliapatti UPHC
Others	DD office Tirunelveli, ANM Training School, District Drug Ware House, DD Office Walk-in Cooler, Regional Public Health Water Lab, Community Interaction at village Deverkulam	Shri Sailakshmi farms (Poultry Farm), Namakkal, Mavureddipati AWC & Mavureddipati AWC, Pachal Higher Secondary School, Community at Mavureddipati, Kulivalavu, Athiappanpalayam & Naruvalar, ASHAs at Powerkadu and Kulivalavu, Health Management Development Institute, Salem (including Skill Lab), TMNSC Namakkal & Bharath Blood Bank (Private Blood bank)

CHALLENGES

- Adequacy of facilities at primary levels especially HSC needs to be ensured in the state to further strengthen the primary health care services. Quality of infrastructure of HSCs needs to be improved in reference to the attached VHN quarters.
- IT system for drugs and logistics management was available only for SDH and DH and needs to be extended to all health care facilities. Health facility wise segregated Essential Drug list is neither displayed nor available at any health facility.
- It has been observed that state has high caesarean section rates. In one of the DH at Tirunelveli, it was as high as 62%.
- The RKSK Programme is implemented in a phased manner in the state. Utilization of Adolescent Friendly Health Clinics is poor and peer educator program is yet to be implemented.
- There is acute shortage of VHNs, adversely impacting the primary health care at HSCs and PHCs.
- The presence of ASHAs in the State is in tribal and inaccessible areas only. There is high drop-out of ASHAs.
- It was observed that funds are transferred through cheque within the sub-linked accounts of DHS.

TRIPURA

REVIEW TEAM

Gomati	Dhalai
Dr. A.K. Puri, ADG Leprosy, MoHFW	Dr. Sher Singh Kashyotia, DD (PH), MoHFW
D P Awasthi, Statistics, MoHFW	Dr Ruchi Jain, AD (PH), MoHFW
Satish Kumar, US AHS	Sh Jagat Hazarika, SRO, Niti Ayog
Vinit Goklani, HR Manager, NHSRC	Ms. Jhimly Bharuah, ITSU-PHFI
Dr. Rajni Wadhwa IPE Global	Ms Pallavi Banerjee,TSA
Dr. Vandana Bhatia, UNICEF	Dr. Vijay Aruldas, AGCA Member
Jahnabi Hazarika, PHFI-IIPH Shillong	Sh Jai Prakash, FP Division, MohFW
Dr. Salima Bhatia, Sr. Consultant, MoHFW	Dr. Yahika Negi, Immunization Division
Ms. Mehak Dua, NHM Finance, MoHFW	Mr Mohammad Ameel, Const-HCT, NHSRC

POSITIVES

- State's initiative of utilizing solar power to provide un-interrupted power supply to provide service delivery at Labour Room, In-Patient Room and for maintaining cold chain is appreciable.
- The monthly ASHA Varosa Diwas is another innovative effort at the facility level, which begins with a teaching session by accredited ASHA trainers. The topics for the monthly teaching sessions are circulated by the state, and local issues given priority as required. This is followed by a quiz designed by the District ASHA Programme Manger or sent from the state, and the correct answers are discussed immediately after the quiz to strengthen learning.
- State has successfully implemented many technology intensive programs in PPP mode like Telemedicine, Teleopthalmology and Teleradiology.
- There are well functional Panchkarma Units and Homeopathic Units at Sub Disrict Hospitals. AYUSH doctors were observed to be practicing their own system(s) of care. There is a regular supply of AYUSH drugs.
- State has a provision for reservations for ASHAs in ANM schools.
- State has a good model of giving preference to doctors who have served in the rural areas during the postgraduate course selection.
- ASHAs have been trained in module 6 & 7, round 5.
- The Community Action for Health has been initiated in Gomati District as Pilot District, the committees have been set up at state and district level, and the state level orientation has taken place.
- The PMU is well integrated with the Directorate. Meetings of the SHM and DHM are being held often, with two to three meetings conducted every year.
- District Health Action Plans are prepared with a bottom-up approach.

DISTRICTS/INSTITUTIONS VISITED

Gomati	Dhalai
CHC - Karbook, Natunbazar	CHC - Manu, Chawmanu
DH -Gomati	DH - Dhalai
SDH - Udaipur, Amarpur	SDH - Longtharai
PHC - Atharobhola, Garjee, Tulamura, Silachari, Tirthamukh	PHC - Salema, Marachara and Ambasser
SC - Purba Garjeechara, Uttar Bagma, Dariya Bagma, Ghorakappa, Suknachari, Bhomrachara,	SC - Chichuchara, Mainama and Shibari, West Chawmanu, East Daluchara, Ambasser and Halhulli
6 Government Schools	CMO and DPMU Office
2 Anganwadi Centres	2 government Schools
ANM Training Institute,	Anganwadi centres
Medical Govt. Degree College	

CHALLENGES

- Prescription audit and grievance redressal system are yet to be instituted.
- Availability of diagnostic services at the facility was fewer in number compared to the list mentioned in National Diagnostics Service initiative (23 vs 57).
- There is no availability of 102/108 ambulances. Tripura state has adequate number of transport vehicles for each facility, however these transport vehicles cannot be labeled as ambulances.
- Constitution and functioning of District MDR Committee is variable. Only facility based maternal death review is being done. Verbal autopsy (community based review) is not being conducted. No maternal deaths reported from the community – indicating weak systems.
- The State has no Human Resource (HR) policy in place.
- Systems for monitoring and Supportive supervision to all levels of facilities need to be strengthened on priority basis in the districts including follow up action taken reports.

UTTAR PRADESH


REVIEW TEAM

Gonda	Firozabad
Dr Pradeep Haldar, DC (Immunization)	Dr K K Mitra, Sr. RD
Dr Suresh Kumar, Asst. Adviser-AYUSH	Dr Sathya Prakash M, Scientist-D, NCDIR
Dr Uddipan Dutta, PAO, NHSRC	Mr Arun Srivastava, Cons NHSRC
Dr Ajay Patle, NRU,	Dr Suresh Shapeti, Sr. Administrative Officer-IIPH
Sh Yogesh Kumar Singh, YP-NITI Aayog	Dr Pradeep Joshi, WHO
Mr Rajeev Prasad, FMG	Dr Nisarg Desai, NHM
Mr Vivek Bhatnagar, AHS	
Dr G C Nanda, AD-AYUSH	

POSITIVES

- AYUSH facilities are available at District Hospital and CHC AYUSH drugs are being procured through District drug store.
- The State has implemented "Free Drugs initiative". EDL drugs list are available at almost all facilities visited and list of available drugs is displayed publically.
- Online Drug Procurement and Inventory Contract System (DPICS) are functional up to district level and is being used for indenting and distribution.
- Majority of Essential diagnostic tests as per free diagnostics initiative, are being provided in the laboratory of the District hospital/CHC.
- 108 and 102 Ambulance services are working well with sufficient utilization.
- FP commodities sufficient at all level of facilities and ANM/SN demonstrated skills in insertion of IUCD at all facility. PPIUCD insertion is being carried out in both the districts. Home delivery of contraceptives was well implemented in the districts. ASHAs are supplied with OCP, ECP, condoms and pregnancy testing kits.
- Home Based New Born Care kit available with ASHAs. Their knowledge regarding the danger signs identification in new-born and mothers was good. Mothers were aware about the exclusive breastfeeding.
- Screening at School and AWC under RBSK is regular.
- Effective supply chain of vaccines at all facilities.
- RKSK training has been initiated in the district and selection of Peer Educators undertaken in many blocks, their training is planned at block level.
- RNTCP is in place and compliant with the protocol, private sector also has started reporting to RNTCP about the occurrence of new cases of TB.
- The state of Uttar Pradesh has launched a programme "SAMPOORNA" in June 2016 for screening of Hypertension, Diabetes, Anaemia, Cervical Cancer and Breast Cancer in females above 30 years of age.
- Human Resource Information System (HRIS) has been developed and is being utilized in deployment of NHM staff.
- 91.12% ASHAs in place against the target. ASHA payment systems have improved substantively which is done by PFMS.
- Grievance Redressal System is in place, at state, district and block levels.

DISTRICTS/INSTITUTIONS VISITED

Type of Facility	Firozabad	Gonda
District Hospital	District General Hospital District Women Hospital District combined Hospital, Sikhohabad	District General Hospital District Women Hospital
CHC	Khairgarh, Sirsaganj, Tundla, Eka	Nawabganj, Manakapur, Paraspar, Belsar, Wazeerganj, Colonelganj, Haldharmau
PHC	APHC - Bachhgao, New PHC – Atepur, New PHC - Padait	Dhanawa, Dumriadeeh, APHC Sonali Mohamadpur
Sub Centre	Atepur, Pratappur, Mandwali, Jaymai	Adhiyari, Khazuri, Dharas (E), Adhiyari, Kanakpur
Others	VHND (Rupaspur)	
Urban Health	UPHC Naglabari. UPHC Ramnagar & UHND Ramnagar (Firozabad town)	Bariyar Purwa Civil lines, Gonda Town

CHALLENGES

- Deadline for construction and operationalization of few health facilities have not been met (e.g. construction work of 100 bedded MCH wing in Gonda is delayed; a regional level Drug Warehouse is yet to become functional; construction of a 30 bedded MCH wing in CHC- Itiyathok is delayed; 100 bedded MCH wing District Women Hospital, Firozabad is completed but not yet functional).
- Facilities termed as FRUs lack the full complement of inputs required for terming a facility as an FRU (Shortage of specialists and lack of blood storage units).
- Blood banks in both the districts are functioning without License.
- Mobile Medical Units and dialysis services are not provided within two districts.
- Use of RCH register has not been initiated in Gonda and ANC services are poor in both the districts. Home deliveries account 32 % of all the deliveries of which only 13 % are attended by SBA.
- Majority of the normal deliveries have stayed less than 24 hours.
- In Non TSU blocks of Gonda and Firozabad, documentation needs strengthening. No standard case sheet was available. No discharge sheet was provided to beneficiary. State can use TSU case sheet in other districts as well.
- Number of sick new-born and mothers referred from the field to higher facilities by ASHA was very low. Counselling over family planning and nutrition is missing in HBNC.
- Antenatal use of Corticosteroids for pre term deliveries yet to pick-up.
- SAM cases identified only in the OPD of District Hospitals are admitted in the NRC, and no referrals from Field level were observed.
- For WIFS program, there is no mechanism for having information from the education department.
- Lack of human resources under NVBDCP programme is affecting the efficiency of the program.
- National Mental Health Programme (NMHP), National Oral Health Programme, National Programme for the Health Care of the Elderly, National Programme for Palliative Care, National Programme for the Prevention and Management of Deafness are not implemented either due to non-initiation or resource constraints.
- State has been a laggard in completing the Module 1 to 4 trainings in the initial years and no trainings of urban ASHAs have been done as yet.
- Awareness on new RCH register is low and no record of high risk pregnancies are maintained.

Notes

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National Health MISSION
Mission of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi